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January 1978
Volume 76
Number 1

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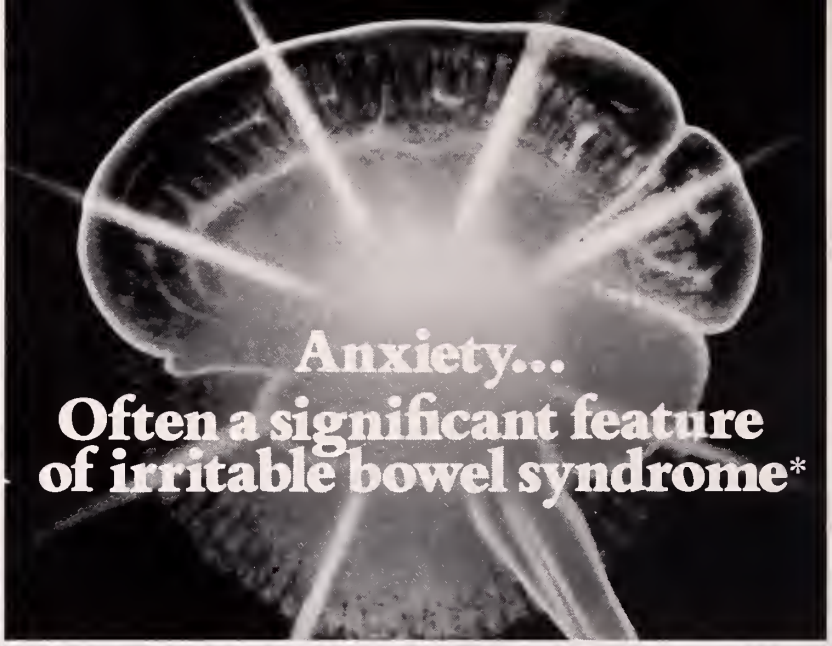
The Journal Of The Kentucky Medical Association



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Final classification of the less-than-effective indications requires further investigation.

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MESSAGE FROM THE PRESIDENT

The AMA

The primary goal for the Kentucky delegation to the AMA in 1978 is the election of Hoyt Gardner as President. Election day will be June 22, 1978, at the Annual Meeting of the AMA in St. Louis. Delegates Harold Haller, Fred Rainey, and I, and Alternates Wally Montgomery, Ken Crawford, and Lee Hess will be there, and you are invited to "meet us in St. Louis" for the fun.

Each time I attend an AMA convention, I am amazed at the pervasive effects of the AMA for all physicians whether members or not. As long as we maintain some semblance of a self-governing profession in a voluntary system, the AMA is the only national representative for all physicians to hospital groups, insurance carriers, the government, and the public, and sometimes protects us from such adversaries as the Federal Trade Commission and Ralph Nader.

The largest budget item for the AMA is for scientific purposes, i.e. disseminating information through publications and meetings.

The position of AMA on the many controversial issues related to health is determined by the House of Delegates. Meeting twice a year, the 270 delegates debate, discuss, and finally vote on each issue. The House elects the 12-person Board of Trustees and five general officers who hire the 900 employees of the AMA and run the organization. The AMA deals with divisive, emotional issues which tend to erode the solidarity of the medical profession. The organization deserves your participation and support as a member. There is no doubt that if we don't hang together, we will surely hang separately.

David B. Stevens, M.D.
Senior Delegate to the AMA

This is the first in a series of articles written at the request of KMA President, John P. Stewart, M.D.

POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

JANUARY

25 "Exercise Testing and Cardiac Rehabilitation**," Louisville Area CME Consortium, St. Joseph Infirmary, Louisville

FEBRUARY

3-4 Burn Symposium*, University of Kentucky College of Medicine, Fee: $75 (physicians), $35 (nurses and physical therapists), Hyatt Regency Hotel, Lexington

14 "Recent Advances in Diagnosis of Portal Hypertension**," Louisville Area CME Consortium, St. Anthony Hospital, Louisville

19-24 Eighth Family Medicine Review*, Session III, 50 hrs. AAFP, Category I-AMA Physician's Recognition Award, Fee: $295, Hyatt Regency Hotel, Lexington

23-24 Breast Cancer Symposium**, Galt House, Louisville

24-25 Fourth International Symposium on Psychopharmacology, University of Louisville Health Sciences Center, (11 prescribed credit hours) Louisville

MARCH

1 "Microvascular Surgery**," Louisville Area CME Consortium, Health Sciences Center, Louisville

10 C. Dwight Townes Memorial Seminar**, University of Louisville Health Sciences Center, Louisville

22 "The Mitral Valve Complex and its Disorders**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29 "Burn Treatment**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29-30 Twenty-fourth Annual Symposium on Cardiovascular Diseases, University of Louisville Health Sciences Center, Louisville

**For further information, contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, University of Kentucky College of Medicine, Lexington 40506*
***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

APRIL

6 Twenty-third Annual Spring Clinical Conference, Lexington Clinic, Lexington

12 "Interplay of X-ray and Endoscopy on Gastroenterology**," Louisville Area CME Consortium, St. Joseph Infirmary, Louisville

14-15 "Diabetes Control: Why and How*," University of Kentucky, Hyatt Regency, Lexington

20-22 "High Risk Pregnancy**," University of Louisville, Executive West, Louisville

24-27 Postgraduate Course in Surgical Anatomy**, Health Sciences Center, Louisville

28-May 1 Fourth Annual Postgraduate Course in Surgery, University of Louisville, Galt House, Louisville

IN SURROUNDING STATES

MARCH

13-15 "The Infertile Female," University of Tennessee Center for the Health Sciences, Holiday Inn Rivermont, Memphis. Contact: Division of Continuing Education, U.T.C.H.S., 800 Madison Ave., Memphis, Tenn. 38163.

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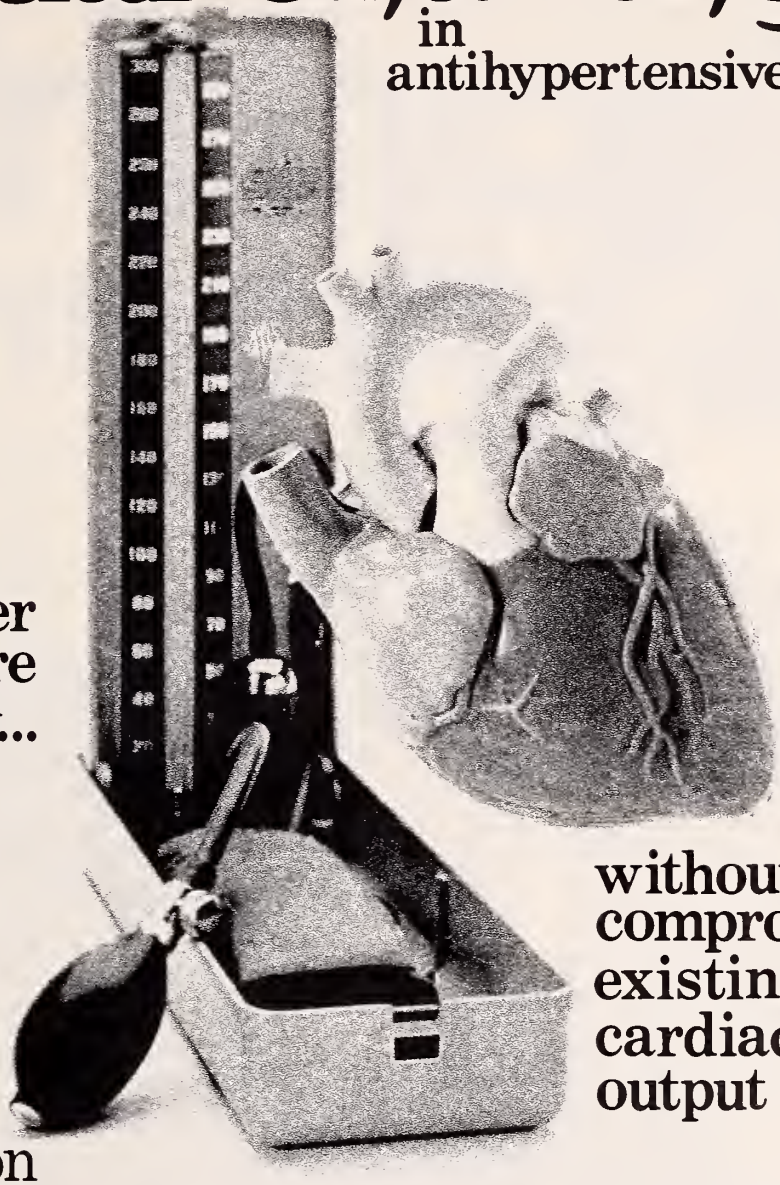

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For a brief summary of prescribing information, please see following page.

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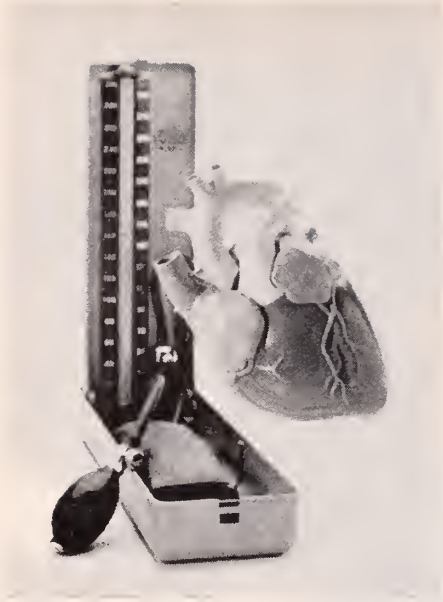

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Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt discontinue the preparation until adequate control by other anti infectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

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The Tardive Dyskinesia Syndrome

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Tardive dyskinesia is a hyperkinetic movement disorder seen following the prolonged use of antipsychotic drugs. The differential diagnosis is presented and drugs which may suppress, modify, or exacerbate movements are discussed. Management guidelines are offered.

THE syndrome of tardive dyskinesia following the prolonged use of antipsychotic drugs is becoming increasingly more evident. No longer is it the purview of psychiatrists and neurologists. With the ever increasing move to deinstitutionalize psychiatric care, many more primary physicians are managing psychotic patients. This, in turn, has led to the need for physicians to recognize the tardive dyskinesia syndrome. The persistent dyskinesias seen following prolonged usage of phenothiazines were recognized in the late 1950's.[1,2] Early descriptions confined the appearance to an orofacial distribution referred to as a buccolinguo-masticatory syndrome.[2] The commonly used term "tardive dyskinesia" (late and persistent dyskinesia) was coined by Uhrbrand and Faurbye in 1960.[3] However, since these early descriptions it is now recognized that the extremities, trunk, diaphragm, and gait are often involved.[4] Most physicians are aware of the acute neurologic effects of the antipsychotic drugs such as pseudoparkinsonism and dystonias. Many are also familiar with the subjective feelings of inner movement or the need to rock or pace seen in akathisia. However, late appearing or tardive dyskinesia is a new entity for some physicians (Table 1).

Clinical Features

Tardive dyskinesia is a constellation of involuntary hyperkinetic movements. These may take the appearance of dyskinesias of the face and oral area, including the tongue, or may be a variety of tics, chorea, athetosis, and dystonias (Table 2). Orofacial movements are the most common to be seen and are more likely to be found in older patients. Common oral-facial movements are a quick, repetitive tongue protrusion (fly-catching) not unlike the tongue flicking of a frog for catching flies. Pouting, sucking, chewing, and twisting of the lips may be seen. When the tongue is examined in the floor of the mouth it may writhe with athetotic movements or it may press repeatedly against the cheek and appear as if the patient is sucking on hard candy (bon-bon sign). In some, the upper lip may repeatedly elevate (rabbit syndrome) with nose twitching.

Table 1

Neurologic syndromes associated with the use of antipsychotic medications

A. Reversible
- Pseudoparkinsonism
  - Masked facies, bradykinesia, rigidity, tremor, drooling, gait disturbance.
- Acute dystonic reactions
  - Oculogyric crisis, torticollis, retrocollis, opisthotonos, trismus, laryngospasm
- Akathisia
  - Subjective need to move, motor restlessness

B. Possibly Irreversible
- Tardive Dyskinesia
  - Hyperkinetic syndrome of face, mouth, extremities, trunk.

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Table 2

Frequent Signs of Tardive Dyskinesia

FACE	
	Blepharospasm
	Tremor of upper lip (Rabbit Syndrome),
	Pouting, Puckering, Smacking of lips
	Chewing movements
	Sucking movements
	Buccal pressing with tongue (Bon-bon sign)
	Tongue protrusion (Fly-catching syndrome)
NECK	
	Retrocollis
	Spasmodic torticollis
TRUNK	
	Axial hyperkinesia (rocking, pelvic thrusting)
	Torsion or athetotic movements
EXTREMITIES	
	Ballistic movements (flinging or flailing)
	Chorea of hands or toes
	Athetosis
	Rotation and/or flexion of ankles
OTHER	
	Grunting vocalizations, asynchronous breathing, myoclonus

Movements in the extremities tend to be restless and choreiform in nature, often with athetosis of the distal extremity. While sitting the patient may show dorsiflexion or tapping movements of the feet. The younger the patient the more extreme these movements may be and can present as bizarre and unusual postures with hyperextension or ballismus. Abnormal movements may appear in the trunk such as copulatory pelvic thrusting while standing. Exaggerated postural abnormalities may be seen as marked lordosis, shoulder shrugging or swaying and rocking. Other less common features can be grunting vocalizations, myoclonic jerking, asynchronous breathing, and upward deviations of the eyes (oculogyric dystonia).

Dystonias (prolonged tonic contractions) may occur in patients exhibiting any of the above dyskinetic features. These are especially common in the axial musculature of the neck and spine and will present as torticollis, retrocollis, or torsion of the trunk. Severe dystonias in adults, where axial dystonia is predominant, are most often in individuals younger than 50 years of age.[4] Reports in children of a syndrome resembling tardive dyskinesia have characterized the movements as much more florid and primarily confined to the extremities with chorea, athetosis, hemiballismus and myoclonus.[5]

Many factors can change the clinical picture of tardive dyskinesia from moment to moment. Variability in the frequency and amplitude of abnormal movements is a hallmark. Having the patient focus on a task generally increases the severity of movements. This is also true if repetitive movements such as finger tapping or walking are attempted. Trying to suppress movements in one part of the body generally enhances the remaining movements. Reduction in movements is seen with drowsiness or sedation and during sleep abnormal movements cease.

Epidemiology

The prevalance of tardive dyskinesia in patients receiving long term antipsychotic therapy has been reported from almost 0 to 40%.[6] There is at present no true figure of prevalence or incidence but many authors feel it is of grave significance even if only 10% of patients on long term drug therapy for psychosis develop tardive dyskinesia.[7] The dyskinesia generally makes a slow insidious appearance while the patient is still taking antipsychotic drugs. Often the first sign will be athetoid movements observed in the tongue while it is resting in the mouth. Dyskinetic movements may appear initially upon discontinuation or reduction in antipsychotic drug dosage. The reversibility of tardive dyskinesia in patients no longer given antipsychotic drugs has been cited by Tarsy and Baldessarini as 20% at 7 to 10 months, 12% at 6 to 24 months, and more or less complete improvement at 3 years.[4] In any event, to date it appears that many patients may continue to display tardive dyskinesia even after complete withdrawal of the offending antipsychotic drug while others will cease their abnormal movements entirely.

Differential Diagnosis

The physician should consider the diagnosis of tardive dyskinesia in any patient who has taken phenothiazines, butyrophenones, thioxanthenes, dibenzoxazepines, or dihydroindolones for at least a few months and who displays orofacial dyskinesia, chorea, athetosis, truncal dystonias, or tics. One must be suspicious of tardive dyskinesia when the onset of abnormal movements coincides with a reduction in dosage or discontinuation of antipsychotic medications. Other drug-related syndromes may confuse the diagnosis. Akathisia (Table 1) is noted for its subjective qualities of inner restlessness and discomfort in the lower extremities. Tremor is often seen with antipsychotic agents and is not a part of tardive dyskinesia. With patients on antipsychotic drugs, tremor is generally reversible and usually

associated with pseudoparkinsonian signs of rigidity and bradykinesia.

Many causes of extrapyramidal dysfunction are known (Table 3) and most can be distinguished from tardive dyskinesia on the basis of medical history, family history, laboratory study, or physical and neurological examination. Spontaneous movements in psychotic patients have been described since the time of Bleuler and Kraepelin. These are usually manneristic, stereotyped, repetitive and purposeless.[8] Huntington's chorea is the spontaneous extrapyramidal disease which is most similar in appearance to tardive dyskinesia. There is usually less oral-facial involvement in Huntington's chorea and the movements are more likely to be incorporated into the patient's normal movements.[9] Family history of abnormal movements, dementia, and early death usually gives important clues to diagnosis. Torsion dystonia usually has an onset between 5 and 15 years of age. Chorea and athetosis are less a feature of the disease than with tardive dyskinesia and severe axial dystonias with a familial pattern and a long progressive history is characteristic.[10] Gilles de la Tourette's syndrome is more common in boys and has an onset between 7 and 15 years of age.[10] Facial grimacing, obscene utterances, and facial tics are characteristic. Like tardive dyskinesia, antipsychotic drugs such as haloperidol may suppress the movements of Tourette's syndrome and these may worsen on discontinuation or withdrawal of the drug. Halervorden-Spatz syndrome is a pathologic rather than a clinical entity and has a peak onset at 10 years.[10] There may be a family history of the illness and rigidity and paresis with pigmentary deposits in the globus pallidus is seen. Death usually occurs within 10 years.

Sydenham's chorea has numerous causes, the most common being rheumatic fever. Most patients are under age 20 and women outnumber men by 2:1.[10] Again antipsychotic drugs, especially chlorpromazine have been used to successfully suppress the movements. Post-encephalitic syndromes are rare but are reported to cause extrapyramidal dysfunction in younger adults.

Hepatolenticular degeneration is an inherited disorder of copper metabolism and is associated with lesions of the basal ganglia and cirrhosis of the liver. It is confined to adults and greenish Kayser-Fleischer rings may be seen in the corneal limbus. Patients with Wilson's disease have diminished serum ceruloplasmin and total serum copper. Albumin bound serum copper increases, on the other hand. Athetoid posturing and grimacing is an outcome of kernicterus. These adults are mentally retarded. Manganese toxicity presents as dementia and an extra-pyramidal syndrome. Serum, urine, and hair shaft manganese levels will be elevated.[11] Chorea may be seen in hyperthyroidism[12] and in hypoparathyroidism where the basal ganglia are calcified.[4]

Table 3

DIFFERENTIAL DIAGNOSIS OF TARDIVE DYSKINESIA

1. Spontaneous movements of psychosis
2. Spontaneous extrapyramidal disease
   a. Huntington's chorea
   b. Torsion dystonia (Dystonia musculorum deformans)
   c. Gilles de la Tourette's Disease
   d. Hallervorden-Spatz Syndrome
3. Infectious or postinfectious extrapyramidal dysfunction
   a. Sydenham's chorea
   b. Post encephalitic syndromes
4. Metabolic or toxic causes of extrapyramidal dysfunction
   a. Hepatolenticular degeneration (Wilson's disease)
   b. Kernicterus
   c. Manganese poisoning
   d. Hyperthyroidism
   e. Hypoparathyroidism with basal ganglia calcification
5. Drug induced extrapyramidal dysfunction
   a. Dihydroxyphenylalanine (L-DOPA)
   b. Alpha-methyldopa
   c. Amphetamines
   d. Drugs with anticholinergic properties
   e. Phenytoin
6. Chorea gravidarum
7. Senile orofacial dyskinesia

The only drug, other than the antipsychotic agents, which often produces an orofacial dyskinesia is L-DOPA. However, it is generally only used in patients with parkinsonism, so differentiation is fairly easy. Choreo-athetoid movements are seen occasionally following alpha-methyldopa. Amphetamines can produce chewing movements and bruxism but generally abnormal movements are more stereotyped than tardive dyskinesia. Anticholinergic drugs can induce movement disorders and antihistamines will cause dystonic reactions in some.[13] Tricyclic antidepressants, which have anticholinergic properties, can produce myoclonus at high or toxic dosages. Toxic amounts of phenytoin have produced choreiform syndromes.[14]

Chorea gravidarum is an uncommon condition seen in one in every 2,000 to 3,000 pregnancies. It is generally observed during the first pregnancy and may cause some confusion in diagnosis in pregnant women who are psychotic and require

medication. Senile oral-facial dyskinesia is not uncommon and may appear in elderly patients who have never been exposed to antipsychotic medication.

Pathophysiology

The frequently irreversible nature of tardive dyskinesia suggests structural changes in the brain. However, neuropathological studies in man show no convincing localization.[15] Many features of tardive dyskinesia suggest a state of relative overactivity of dopamine neuronal systems in the brain or possibly a receptor supersensitivity to the pharmacologic actions of dopamine. For instance, the abnormal movements of tardive dyskinesia worsen when dopamine antagonizing drugs such as chlorpromazine or haloperidol are withdrawn. An increase in brain dopamine levels with the administration of L-DOPA also exacerbates the movements. Drugs such as reserpine or haloperidol that deplete or block dopamine will suppress movements.[16] There appears to be an interaction between dopamine and acetylcholine in the basal ganglia and a hypofunction of acetylcholine may be present with a relative dopamine excess or receptor supersensitivity. In general, anticholinergic agents will worsen tardive dyskinesia and cholinergic agents, such as physostigmine, have had variable results.[17,18] In short, the prolonged and often irreversible nature of tardive dyskinesia may represent irreversible neurotoxic or neuropathologic changes involving dopaminergic and cholinergic neurons or possibly their complex interactions in the basal ganglia.

Management

Quitkin and others have recently reported data which suggests that the first signs of tardive dyskinesia may be reversible.[19] At the appearance of signs of tardive dyskinesia, if the patient is still taking antipsychotic drugs, every effort should be made to discontinue the medication. This is especially true in younger patients in whom there is a greater likelihood of reversibility and in whom the illness may reach incapacitating or cosmetically undesirable proportions.[20] The physician should be prepared for an initial worsening of the dyskinesia upon removal or reduction in dosage of the antipsychotic agent. Hopefully, with time the abnormal movements will decrease in severity. Obviously, in some cases there is no alternative but to continue the medication and the lesser of two evils must be chosen, psychosis or tardive dyskinesia. For many, however, at least a lowering of dosage can be achieved. Many medications will suppress, modify, or worsen movements. These are outlined in Table 4.

Table 4

DRUGS AND TARDIVE DYSKINESIA

A. Possible suppressors
  1. Dopamine blocking agents
    a. Phenothiazines (e.g. chlorpromazine, Thorazine)
    b. Butyrophenones (e.g. haloperidol, Haldol)
    c. Thioxanthenes (e.g. Thiothixene, Navane)
    d. Dibenzoxazepines (e.g. Loxapine, Loxitane)
    e. Dihydroindolones (e.g. Molindone, Moban)
  2. Amine depletors
    a. Reserpine
  3. Catecholamine synthesis blockers
    a. Alpha-methyldopa
  4. Catecholamine release blockers
    a. Lithium Carbonate
B. Agents with variable effects
  1. Amantadine (Symmetrel)
  2. Antihistamines
  3. Sedative-Hypnotics
  4. Benzodiazepines
  5. Methylphenidate (Ritalin)
  6. 2-dimethylaminoethanol (Deaner)
C. Agents that exacerbate
  1. Anticholinergic agents
    a. Antiparkinson agents (e.g. Artane, Cogentin)
    b. Antihistamines
    c. Tricyclic antidepressants (e.g. Elavil, Tofranil)
    d. Atropine like antispasmodics
  2. Dopamine like agents
    a. L-DOPA
    b. Amphetamines

Before attempting to treat the dyskinesia, it should be determined whether suppression of the movements is clinically needed. Most chronically psychotic patients are unaware of their movements. However, some psychotic patients are concerned and most neurotic or personality disorder patients will be concerned. Individuals who are employed, or where axial or limb dystonia interferes with functions, may require suppression.

If suppression is needed, an antipsychotic drug such as haloperidol, trifluoperazine, or chlorpromazine may be tried and the lowest effective dosage determined. Anticholinergic antiparkinson agents generally worsen tardive dyskinesia and should be avoided. Deanol has received attention as a possible acetylcholine precursor for use in tardive dyskinesia but results to date have been disappointing.

The physician should probably avoid the use of antipsychotic drugs for mild neuroses, personality disorders, and functional complaints unless

significant symptomatology is present, due to the risk of tardive dyskinesia. However, antipsychotic drugs may be helpful in patients with high amounts of distractibility, those with racing thoughts or thought blocking, anxious obsessional patients, and anxious patients refractory to benzodiazepines. It should be noted that the two newest antipsychotic drugs, molidone (Moban) and loxapine (Loxitane) list the signs and symptoms of schizophrenia as their **only indications** for use. Physicians should probably exercise caution at this time in using these drugs for patients who are not psychotic due to potential medicolegal risks secondary to the development of tardive dyskinesia in nonpsychotic patients.

In summary, the pharmacologic treatment of tardive dyskinesia is presently unsatisfactory. Short-term suppression of movements can be obtained with phenothiazines, butyrophenones, or other antipsychotic-antidopamine drugs. However, movements tend to recur, necessitating an increase in dosage. This leaves the physician in the unfortunate position of using the offending agent to treat the disorder, and possibly removing chances of spontaneous recovery. Further knowledge and experience with this disorder is needed before fruitful guidelines in management can be provided.

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Myocardial Lacerations vs. Time

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Yesterday the successful treatment of heart lacerations was chancy in large surgical centers. Today, down in the boondocks, it is still this way and this type of wound is not uncommon.

The first major study of heart injury in the United States was done by C. S. Beck.[1] This was continued by Kentucky surgeons at Louisville General Hospital: R. Arnold Griswold and J. C. Drye.[2] These Kentucky scientists by their success gave early heart surgery a great push forward.

I feel that their accomplishments are comparable to the impetus of other Kentucky physicians —Ephraim McDowell, Walter Brashear, and Fred Rankin, who carried the art and science of surgery forward across the years.

Anatomy of the Wound

People with injuries to heart valves and to the heart's conduction system are unlikely to become patients at any hospital. If the pericardial sac laceration is large there is no chance of protective tamponade to form and the patient exsanguinates. The above forms the 60 to 80% of persons who are dead on arrival. The remainder have an initial pericardial sac wound that is small and a myocardial laceration that is large to small, with life protected from minutes to hours by the tamponade.

Method of Management

Pericardiocentesis,[3] using long needles, leads to treatment failure in desperate cases. It is best used as a diagnostic method rather than a definitive method of therapy.

When required, one method of approach is via a small midline upper abdominal incision, followed by penetration of the floor of the pericardial sac with long curved scissors. The reason for this is that much of the pericardial sac in these cases contains clotted blood and the use of a small or large bore needle is useless.

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The general policy of management of penetrating wounds of the heart or myocardial lacerations has changed to a more aggressive approach in the last few years. Now almost all cases are treated with immediate thoracotomy and cardiorrhaphy, giving improved results.

On arrival the suspected heart laceration patient should be taken immediately to the operating room for study, resuscitation, and possible surgery. Five cases from Owensboro-Daviess County Hospital surgery department are reported here.

First case: A 36-year-old black male was brought to the Owensboro-Daviess County Hospital emergency room with stiletto wound left fourth inter space. He was in shock and was taken to surgery with left anterior thoracotomy relief of tamponade and suture of 3/4″ hole in left atrium. His remaining hospital course was stormy. The patient had open heart surgery in Louisville 45 days later to close an atrial septal defect. He was asymptomatic with no sequela after the second surgery.

Second case: An 18-year-old black male was brought to the emergency room via local ambulance from poolroom. He had a stab wound of left chest and was in shock. Surgery involved a left thoracotomy with suture of lacerated right ventricle and relief of tamponade. The patient's remaining course was uneventful and he left the hospital in good condition with no sequela.

Third case: A 17-year-old white male was brought to the emergency room with 5mm caliber gunshot wound of the heart. He was in shock. The tamponade was decompressed in the emergency room. The patient expired during surgery.

Fourth case: A 53-year-old white female was brought to the emergency room by her husband with a gunshot wound of the heart with 25 caliber pistol. Surgery consisted of left thoracotomy, pericardiotomy, and suture of the lacerated left ventricle. Her postoperative course was stormy due to schizophrenia. There was no sequela.

Fifth case: A white male, age 16, was brought to the emergency room by ambulance with a stab wound in the right hemothorax. He was in shock and a right thoracotomy was performed with

suture 1″ hole in right atrium. He had minimal tamponade and almost exsanguinated. His post-operative course was normal with no sequela, except for skin grafting of his right arm.

Discussion

The vital factor of each of the five cases was tamponade. The tamponade slowed down the hemorrhage giving time to repair the laceration or, if existing too long as in case #3, resulted in losing the patient on the table. All patients could have been saved had they been wounded on the hospital steps.

An important factor in these five heart cases is the ready availability of anesthesia, operating room facilities, and personnel.

Summary

The most important factor today is immediate evacuation from site of action or injury to the hospital. Transportation must be immediate. Cases #4 and #5 were transported 25 to 30 miles but with little delay. Case #3 was only 7 to 8 miles away but had delay. Cases #1 and #2 were within the city and immediately taken to the hospital. Most cases of heart laceration have no time or only long enough time for a one-way move to the hospital.

Modern EMS systems have yet to come to 80% of Kentucky and it is felt that vocational schools and colleges could help train people in this field.

This is truly a field that federal, state, and local officials should become deeply involved in. Without cooperation and effort by all, the survival rate of today's trauma victims will reman as is.[4]

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Congenital Lipoma of the Orbit

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An unusual case report is presented of a primary encapsulated lipoma which caused an increase in size of the orbital wall without any damage to the globe or eye muscle.

Primary lipomas may arise anywhere in the body but those arising in the orbit are rare. Reese (*Arch of Ophthal* 41:198, 1949) stated that primary orbital lipomas are rare, and it is probable that specimens reported as lipomas are nothing more than orbital fat.

The present case is of particular interest as an intensive review of AMA information resources revealed only two articles relating to intra-orbital encapsulated lipomas.

Case Report

The patient, an 11-year-old white female, was seen in the office on November 24, 1976, for a tumor of the right eyeball. Her mother stated that the child had had this tumor since birth and that in the last couple of years it seemed to become larger and push the eyeball inward.

On physical examination the right eyeball turned medially about 10-15 degrees and was unable to rotate laterally. A large mass protruded from the superior rectus laterally to the inferior rectus inferiorly and extended almost to the lateral limbus. Vision in each eye was 20/15; Fundi was normal with slight pushing in of the lateral orbital wall.

X-ray examination of the orbits with special reference to the right side revealed the right orbit to measure 4 cm in the transverse diameter and the left to measure 3.8 cm. The right orbit measured 4.5 cm in height and the left 4.2 cm. The optic canals were normal. The changes suggested either enlargement due to a long standing benign tumor or a congenital difference in the heighth and width. In the base view, the posterior lateral walls were the same posteriorly with a mild right lateral flaring of the anterior 2 cm.

At surgery the conjunctiva above, below, and around the tumor was elevated with novacaine and adrenalin 1.20 cc. The incision was made lateral to the tumor in order to save as much conjunctiva as possible. With the use of the microscope, the mass was dissected downward past the equator within a few millimeters of the optic nerve. Then on the orbital side, the mass was dissected from the lateral external rectus tendon and muscle and the lateral half of the superior and inferior rectus muscles. The external rectus muscle and tendon were thinned almost beyond recognition due to pressure from the tumor mass. The entire tumor mass (encapsulated) was removed intact. The conjunctiva was sutured. A slightly hollow area was left between the lateral wall of the orbit and the globe. (*Authors note:* At the conclusion of the operation, I wasn't sure whether the external rectus muscle and nerve had been damaged by the pressure of the tumor.)

The pathology report described a well circumscribed mass measuring 2.5 x 2 x 1 cm. Multiple-cut sections showed mature lobular fatty tissue. The lipoma was an intact encapsulated tumor.

Comment

All tumors of the orbit should be carefully watched. If there is any increase in growth, they should be removed before any damage to the eye can be done. In this case, fortunately, the patient regained full motion of the eye in the primary, secondary and tertiary position of gaze.

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Clinical Observations

Retrocecal Appendicitis†

James P. Moss, M.D. and Britt West, M.D.
Louisville, Kentucky

Both the primary physician and surgeon may be caught unaware by the clinical presentation of true retrocecal appendicitis. Studies published in the *New England Journal of Medicine* reveal that physicians arrive at a diagnosis by recognition of a clinical pattern. Since the "atypical" presentation of retrocecal appendicitis does not coincide with the usually recognized symptoms of appendicitis, a delay can result in diagnosis and management while emphasis is placed on diagnostic studies which may be misleading.

Patients with retrocecal appendicitis frequently have a history of pain of longer duration than the usual case of appendicitis. Often the onset of pain is in the right lower quadrant with a duration of 16 to 24 hours and occasionally even one or two days. Anorexia is usually present but nausea and vomiting are not prominent symptoms. The complaint of right flank pain is the first "red-herring" in the diagnosis and the patient may be given antibiotics for a urinary tract infection further confusing the clinical picture.

The initial physical examination is remarkable in that flank or lumbar tenderness may be the most significant finding. The patient may not appear acutely ill, is often afebrile, and abdominal signs can be minimal. The rectal examination is almost always negative, however a positive psoas sign is a clue. Inflammation near the psoas muscle causes the characteristic gait favoring the right hip or may cause the patient to lie on the examining table with flexion or internal rotation of the leg.

The laboratory data are not specific and may even lead the physician away from the correct diagnosis. The white blood count is frequently, but not always, elevated. There may be increased numbers of white blood cells in the urine because of the appendix's proximity to the ureter. Pyuria with flank pain can reinforce the erroneous diagnosis of a urinary tract infection. Following the use of antibiotics, subsequent laboratory data and physical examination become even more difficult to interpret. A barium enema, I.V.P. or plain x-rays of the abdomen may be of little diagnostic assistance. Air in the cecum or in a loop of small bowel in the right lower quadrant may suggest a localized ileus secondary to inflammation. The I.V.P. may show some spasm of the ureter but it is not diagnostic. A barium enema can appear "normal" even in the presence of a large retrocecal abscess.

Significant delay in diagnosis and treatment is associated with increased morbidity and mortality. A retrocecal abscess may extend through the retroperitoneum into the upper abdomen and subphrenic space. Septicemia, inanition, and pelvic phlebitis can occur. With a delay in management, surgical complications are also increased including wound sepsis and rarely a fecal fistula.

Physicians should maintain a high index of suspicion for retrocecal appendicitis in patients who present with right-sided abdominal or flank pain. Laboratory data can be misleading and more reliance should be placed on a physical examination and presence of persistent localized tenderness and guarding in the right lower quadrant. Prompt surgical intervention based on an accurate history and careful physical examination will reduce the mortality and morbidity from retrocecal appendicitis.

†*From the Department of Surgery, University of Louisville School of Medicine, Louisville*

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In general, the preferred topical formulations for lesions in specific areas are: solutions for scalp lesions, creams for moist areas/lesions, and ointments for dry areas/lesions. The studies cited above, however, were not limited to lesions in these specific areas.

*Majority of patients evaluated after 2 weeks' therapy. Data on file at Squibb Institute for Medical Research.

See next page for brief summary.

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CONTRAINDICATIONS: Topical steroids are contraindicated in vaccinia, varicella, and in those patients with a history of hypersensitivity to any of the components of the preparations. These preparations are not for ophthalmic use.

PRECAUTIONS: *General*—If local infection exists, suitable concomitant antimicrobial or antifungal therapy should be administered. If a favorable response does not occur promptly, application of the corticosteroid should be discontinued until the infection is adequately controlled. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid and suitable precautions should be taken. If irritation or sensitization develops, the preparation should be discontinued and appropriate therapy instituted. Although topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use during pregnancy has not been absolutely established; therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, striae, skin atrophy, secondary infection, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings: maceration of the skin, secondary infection, skin atrophy, striae, and miliaria. Contact sensitivity to a particular dressing material or adhesive may occur occasionally (see PRECAUTIONS).

For full prescribing information, consult package insert.

HOW SUPPLIED: The 0.025% and 0.1% Cream and the 0.1% Ointment are supplied in tubes of 15 g. and 60 g., and in jars of 240 g. (8 oz.). The 0.1% Solution is supplied in plastic squeeze bottles of 20 ml. and 60 ml.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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ORAL SUSPENSION

a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

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7 **Professional Corporations in Perspective** (OP-102) $3.25
1977 publication which features: economic factors, advantages and disadvantages of incorporation; effect of ERISA on professional corporations; choosing a retirement plan; and managing a professional corporation.

8 **New Doctor's Kit** (OP-458) $10.00
Contains: **The Business Side of Medical Practice; Planning Guide for Physicians' Medical Facilities; AMA Publications Lists; Group Practice Guidelines; Current Procedural Terminology** order form; Uniform Health Insurance Claim Form; **Medicolegal Forms; Talking with Patients; Preparing a Patient Information Booklet;** AMA membership information; Placement Service; and bibliography on billing systems, recording keeping systems, etc.

9 **Group Practice Kit** (OP-457) $7.50
Contains: **Group Practice Guidelines; Professional Corporations in Perspective;** medicolegal reprints on such subjects as: professional liability, confidentiality, informed consent, etc.; samples of model legal agreements for a physician and employed associate, office sharing, medical partnerships, and forming a corporation.

SPECIAL ARTICLES

Medical School Responsibilities in Service and the University of Louisville Medical School Fund, Inc.

Arthur H. Keeney, M.D.*

All U.S. medical schools have faced revisions in their service activities since the introduction in 1966 of a guaranteed, federal intermediary payor. Medicare and Medicaid were designed to provide for medically disadvantaged patients, the equivalent of access to private physician care. Though initiated without particular consideration of teaching physicians and surgeons, the program has progressively led to relocation of many patients from the classical teaching settings often associated with city, county, or entirely charitable hospitals. In the ensuing dozen years many charitable hospitals have modified their programs to accommodate a segment of private patients previously excluded; some sprawling and less attractive institutions literally closed their doors; others tried valiantly to create a one class service without differentiation between charitable and self-reliant patients.

At the University of Louisville School of Medicine a plan entitled "Clinical Service Associates" (CSA) was incorporated with a formal Board of Directors shortly after the establishment of Medicare. Thus, professional funds derived from patient care in the usual setting of General Hospital and without identification of private physician-patient relations were directed into the CSA Corporation through its own billing and collecting system separate from that of General Hospital. These funds were then turned over annually to the University of Louisville Foundation, Inc., and the net receipts made available as 10% to the general operation of the School of Medicine and the remainder returning to the departments responsible for its generation. Though this plan was challenged legally, such a system has become usual throughout most U.S. medical schools in the past decade.

More recently, this school, along with approximately 100 other sister schools, has moved to more responsible identification and accounting of other faculty generated fees derived in the setting of private practice. As it is essential for young physicians to learn by doing, it is essential for faculty to demonstrate and strengthen not only the current state of the arts in their fields, but to contribute to advancement and improvement of medical and surgical treatment skills. In Louisville the medical faculty is increasingly sought out for its capabilities to patients. In the past, faculty efforts were largely circumscribed to "attendance of the poor" and largely limited to indigents relying on General Hospital.

During 1973-75, a faculty committee, in consultation with approximately 125 faculty members, evolved a Medical School Professional Practice Plan which, after several reviews and modifications, was officially accepted by the Trustees of the University of Louisville and by the Executive Faculty of this School of Medicine. By written agreement this plan became effective February 1, 1976. In keeping with approximately 95% of plans for private practice in the roughly 100 medical schools which are state-related, this plan obligates participation of *all* faculty members who are full-time and who generate income by professional activities. Excluded are royalties from medical books, prizes, and certain patent rights handled in keeping with USPHS and U of L procedures.

Though these plans have been contested by occasional faculty members in other schools and by faculty in this school, our plan has now completed a year and a half of operation, and like the CSA, is responsibly accounting for faculty

*Dean, University of Louisville School of Medicine, Louisville

earnings and generating additional support necessary for the school. The U of L plan is a relatively generous one to the individual faculty member and permits all legitimate IRS deductions before accounting to the school. Apportionment is then made between the faculty members and fund with a greater percentage to the school as the total rises. Five percent of the net funds go to the Health Science Center for interinstitutional commitments such as the library, Biomedical Learning and Resources, etc.; 10% accrues directly to the School of Medicine for areas of general need. The residual 85% is distributed to the departments where it is generated or to the sections within such departments when sections conduct established residency programs or have three or more faculty members. To date, returns to individual departments have varied from less than $100 in a few of the basic science departments where there is little direct service to nearly $100,000 in departments with major service opportunities and obligations. Approximately 100 faculty members have made individual payments into the Medical School Fund, Inc.

Public accountability is an increasing issue of the 1970's, and the medical school faculty, by overwhelming majority action, acknowledged these responsibilities in 1966 through the establishment of the CSA and again in 1976 through the establishment of the Professional Practice Plan. Neither of these steps has been without some distaste and feelings of intrusion. The Professional Practice Plan, however, provides some appropriate direct financial return to those faculty members who meet service obligations, both at scheduled and unscheduled hours of the day or night. The plan also commits the faculty to team responsibilities and provides a curb of decreasing percentages of individual returns as earnings mount.

The medical school is making distinct academic progress. Its current accreditation is secure. Some programs are singularly strong and others are moving into positions of greater strength. These responsibilities in handling service derived fees represent an increasing accountability and willingness, literally, to stand up and be counted.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words; the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

In submitting a manuscript, the author is requested to include a concise summary, not to exceed 35 words, to be used as a sub-title when the article is published in The Journal. The purpose of the summary is to create additional interest and encourage greater readership.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. The editors may use up to six illustrations with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, P.O. Box 32030, Louisville, Ky. 40232.

The bylaws of the Kentucky Medical Association provide that all scientific discussions and papers read before the KMA Annual Meeting shall be referred to the KMA Journal for consideration for publication. The bylaws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky Medical Association, 3532 Ephriam McDowell Drive, Louisville, Louisville, Kentucky 40205.

EDITORIAL

Can the "Kudzu" Be Controlled?

The plant, kudzu, is a very special organism. Taken as a leaf, or even with a yard of its vine, it is a beautiful, succulent thing. Planted on the steepest embankment it grips the soil tightly so none washes away. Ruminants relish it. Altogether it is a splendid thing—except that it is almost impossible to control. Kudzu is that large-leafed vine one sees growing across our Southland, smothering acres of farms, choking out trees, and vaulting to new locations by climbing across electric lines.

The very first Bureau, like the very first kudzu vine, may well have been a thing of beauty. Perhaps the first such Government office, staffed to create a better, safer life for the citizens, was as efficient and pragmatic and as resourceful as that first kudzu vine. So it is not difficult to see kudzu as a metaphor for the way in which authoritative controls seem to creep over our modern American existence.

Only rarely does one see a real life situation which baffles those who seek to regiment our lives. However, just for the record, a small example of only symbolic significance can be found at the Watterson Expressway and Newburg Road Interchange in Louisville. Travelling west on the Watterson, turning north on to Newburg Road, one soon comes to a simple stop sign at the edge of a complicated intersection. This intersection is festooned with lights which diligently, if mindlessly, channel most of the traffic into its many directions. But we, at our stop sign, have no light at all. Apparently the planner, in his exasperation with the complexity of the thing, simply decided to make the traveller on our road responsible for his own welfare and that of others. Accordingly, we must come to a stop, note the flow of traffic, then move squarely into and through the intersection in the direction of our choice. It's a heady, even exciting experience. Someone trusts us! Someone felt we could come to a stop, evaluate the existing flow of traffic, make a choice and act on it.

Well, we mustn't expect this sort of thing to proliferate in traffic control. We seem to need most of the regulation that we have, but one of the great characteristics of burgeoning bureaucracy is its lack of discrimination. Bureaucracy will tackle anything. No area of human interest or endeavor is safe. If, in America, it seems to be less pervasive than in some other countries, the current signs and directions are not encouraging.

Medicine needs some controls. For example, we need licensure of practitioners. But in the rush to organize us into more easily managed cadres, there seems no discrimination at all. Medicine is big, nearly ubiquitous, and entirely necessary. Accordingly, it most surely offers fertile ground for those who see power and jobs in advancing controls.

Unfortunately, for all its apparent strength, Medicine has a fragile quality. It is not just a structure which can be levelled and rebuilt better by the well-meaning (much less by the other kind). Instead Medicine is a living thing and can be poisoned. It will not die, but it can be so changed that even our greatest critics will eventually be appalled at what they have wrought.

Those champions of controls, those kudzu vines of the Government, do not hear our cautionings and would be unafraid if they did. So we must, instead, enlighten them when we can, resist when necessary, and always show Medicine's basic integrity, carrying out traditions of quality, rigorously controlling ourselves from within.

Our best defense seems to be this integrity and this quality both in personal lives and private practice. Even so, this may not be a cure for bureaucratic kudzu, but still it offers a hope and even a little hope is better than none.

DLS

J. Duffy Hancock, M.D.
1898-1977

James Duffy Hancock, M.D., KMA President 1953-54, passed away at his home on November 22 at the age of 79. His service to medicine, not only in Kentucky but in the entire nation, was of the highest caliber. He was a respected leader in numerous surgical and other professional organizations and was held in high regard by all those he served.

Born in Jeffersonville, Indiana, on November 1, 1898, Doctor Hancock received the combined degrees of Bachelor of Science and Doctor of Medicine from the University of Louisville in 1921. Decorated for his valor as a Major in the Army Medical Corps during World War II, he was discharged in 1945 with the rank of Colonel. Resuming his general surgery practice, which he had begun in 1923 in Louisville, Doctor Hancock continued until his retirement in 1975.

His contributions to the Kentucky Medical Association are much too numerous to list in detail, but in addition to his term as President, he was a Vice-President (1938-39), AMA Delegate (1939-42, 1951-52), Orator in Surgery (1946-47), and was the 1965 recipient of the Distinguished Service Award.

A Fellow of the American College of Surgeons, Doctor Hancock was a past president and councilor from Kentucky of the Southeastern Surgical Congress and a past president of the Kentucky Surgical Society. He was a former Trustee of the Southern Medical Association and a past chairman of the National (Medical) Advisory Committee of the Social Security Administration, for which he received the "Director's Citation."

His other accomplishments, honors, and activities are too numerous to mention in this brief tribute, but they all point to the sincere dedication this physician had to his family, his patients, his colleagues, and his community.

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- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert®/25
(meclizine HCl) 25 mg. Tablets
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome, Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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aspirin, 227 mg; phenacetin, 162 mg;
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ASSOCIATIONAL NEWS

KMA To Form Its Own Professional Liability Insurance Company

The KMA Board of Trustees, meeting December 14-15, voted to form its own insurance company to sell both **primary and excess** professional liability insurance. Resolution Q, passed by the KMA House of Delegates in September, requested the Board to establish such a company.

KMA has conducted a thorough investigation into all phases of setting up its own company and has concluded to proceed in a joint venture with the Physicians Insurance Company of Ohio (PICO), a company formed by the Ohio State Medical Association for Ohio physicians.

As a first step, KMA will immediately establish a Kentucky Medical Insurance Agency which is anticipated to sell 100/300, 200/600 and one million dollar excess occurrence type professional liability insurance coverage which will be offered by PICO.

In order to purchase coverage, a set contribution to surplus will be held in escrow until such time as a sufficient reserve has been established when it will be converted into stock to form the KMA company.

Policies will become available as soon as PICO can meet the requirements of the Department of Insurance to sell policies in Kentucky and the Kentucky Medical Insurance Agency can be formed. It is anticipated this will be completed around mid-March or early April.

Some of the factors influencing the Board's decision were:

- Establishment of the Patients' Compensation Fund through the Kentucky General Assembly would have the disadvantage of an uncertain outcome and also has the potential for being again ruled unconstitutional at a later date.
- The Patient's Compensation Fund, if voluntary, as mandated by the House of Delegates, could require contributions as high as 45 to 100% of the basic coverage premium to be financially viable. In addition, it was felt the power of unlimited assessment would also have to be given to the Commissioner of Insurance in the event participation in the Fund was limited and awards paid by the Fund depleted it.
- Physicians are more likely to purchase stock in a company when a policy is immediately available.
- A physician-owned company can write other lines of business which, if profitable, can possibly help reduce premiums.
- A physician-owned company gives physicians complete control over underwriting and claim investigations.
- Kentucky physicians will not have to be dependent on the whims of legislators, judges, and attorneys for the direction of their future insurance coverage.
- Kentucky doctors will review applicants.
- Claims judged defensible will be judged by Kentucky physicians.

More information will be forthcoming as plans become implemented. Watch for further issues of the "Communicator" and KMA *Journal* for additional information or contact the Headquarters Office.

Campaign Gets Underway To Elect Dr. Gardner as AMA President

The candidacy of Hoyt D. Gardner, M.D., Louisville, for AMA President-Elect, got officially underway during the December AMA Interim Meeting in Chicago. Doctor Gardner, who announced his candidacy in September at the KMA Annual Meeting, has opposition from one other candidate, Jere W. Annis, M.D., Florida. The election will be held at the 1978 AMA Annual Meeting in St. Louis next June.

Doctor Gardner

Currently serving his second term as AMA Trustee, Doctor Gardner is a past president of the Jefferson County Medical Society and the Kentucky Medical Association. He is also a past chairman of the AMPAC and KEMPAC Boards and served on the AMA Council on Legislation.

David B. Stevens, M.D., Lexington, Chairman for the Gardner Campaign Committee, has asked that the membership assist in this campaign by contacting constituents in other states who are delegates to the AMA and state medical officers to seek their support for Kentucky.

Members wishing to participate in the campaign financially are asked to send a check, payable to the Gardner Campaign Fund, to the KMA Headquarters Office.

Seven Kentucky physicians have been elected to the Presidency of the AMA, the last one being Elmer Henderson, M.D., in 1950.

Annual Meeting Plans

September 24-28, 1978
Hyatt Regency/Lexington Center

Two Kentucky Health Leaders Honored During Recent AMA Meeting

Fred C. Rainey, M.D., Elizabethtown, was appointed to the American Medical Political Action Committee (AMPAC) Board of Directors during the AMA Interim House of Delegates Meeting held December 4-7 in Chicago. Nominated by KMA for this position, Doctor Rainey previously served two terms as Chairman of the KEMPAC Board of which he continues to serve in an ex-officio capacity.

Doctor Rainey

A past president of KMA, Doctor Rainey has been actively involved on numerous KMA committees. He currently serves as Chairman of the KMA National Legislative Activities Committee, having been a member for eight years. A KMA Delegate to the AMA since 1974, Doctor Rainey serves on the AMA Council on Legislation.

At the December 4-7 meeting of the American Medical Association. the House of Delegates voted to honor J. Ed McConnell, Louisville, by presenting him a Citation of a Layman for Distinguished Service. The award will be presented at the AMA Annual Meeting to be held June 17-21 in St. Louis.

Mr. McConnell

A KMA nominee for this award, Mr. McConnell has been extremely active in the health care field in Kentucky and in the nation. He retired in 1976 as President of Kentucky Blue Cross, Blue Shield and Delta Dental and currently is Advisory Chairman of the Corporate Boards of that organization.

Honored in similar fashion by KMA and the Kentucky Hospital Association in recent years, Mr. McConnell is a past president of the Kentucky Chamber of Commerce and served on the Board of Directors of the National Association of Blue Shield Plans.

Trustees' Report

EIGHTH TRUSTEE DISTRICT

Richard J. Menke, M.D., Covington

The three-county area which comprises the Eighth Trustee District are entering the winter season 1977 with considerable activities taking place. The joint meeting of the Campbell-Kenton and Boone County Medical Societies was held November 3, 1977, and was well attended. This was also the case for the Christmas dinner dance meeting of the Campbell-Kenton County Medical Society on December 8, 1977. At the latter meeting, Richard Allnut, M.D., was installed as the incoming President for 1978.

Approximately 20 new physicians have begun practice in Northern Kentucky since July 1, 1977. Among them are practitioners in the medical and surgical specialties as well as family practice.

Work continues on the new St. Elizabeth South Hospital just off I-275 and completion is expected in mid-1978. Ground has been broken on the new William Booth Hospital to be located in Boone County adjacent to I-75. Approximately two years will be needed to complete that hospital. St. Luke Hospital in Campbell County has opened a new floor since July 1, primarily for surgery.

Governor Julian Carrol was in Northern Kentucky on December 6, 1977, for the dedication of the final western link of I-275 which became operational that day. This portion of the expressway completes the roadway from I-75 in Northern Kentucky westward across the Ohio River, through Indiana and western Hamilton County to join with I-75 again north of Cincinnati. The dedication ceremony was marred somewhat by the early winter storm which forced all activities indoors. Completion of the eastward final link across the Ohio River will probably not occur for approximately two years, awaiting the completion of the Ohio River bridge at Brent, Kentucky.

With all the present and anticipated growth in Northern Kentucky the members of the Campbell-Kenton and Boone County Medical Societies look forward to the year 1978 with a great deal of optimism.

SIXTH TRUSTEE DISTRICT

Earl P. Oliver, M.D., Scottsville

The year 1977 with its adverse ruling by the Kentucky Supreme Court on our Malpractice Liability Insurance Law is now a part of our past and we should put it behind us.

We must turn our energies toward the future and contact our Kentucky legislators and urge them to support legislation which would enact into law the portions of the Medical Liability Insurance Law which were not objected to by the Supreme Court. We must further urge our legislators to enact a separate confidentiality law as well as other legislation supported by the KMA.

On a local level the Sixth Trustee District reports that a malpractice suit brought against a Warren County physician approximately four years ago has been successfully defended and decided against the plaintiff after lengthy court procedures. Bowling Green and Warren County also report that the bonds to build a new City-County Hospital have been sold, and construction will soon start. Construction had been held up for almost a year at the added expense of about $4 million due to court actions by labor unions. In other news, George Watson, M.D., pediatrician, recently located in Bowling Green.

Barren County reports that David Fant, M.D., a resident of Glasgow, is now in active practice in Edmonton. It has been rumored that Glasgow is under consideration to become a regional KPRO center.

Logan County reports the addition of two new physicians in the past few months: Jareka Patak, M.D., surgeon, and his wife, Kunja Patak, M.D., obstetrician-gynecologist.

FOR 1978

Here's hoping you are always on top of the hill
Where the coasting is easy!

Bud Ernst * Ray Jones * Judy Parker

A. P. Lee Agency

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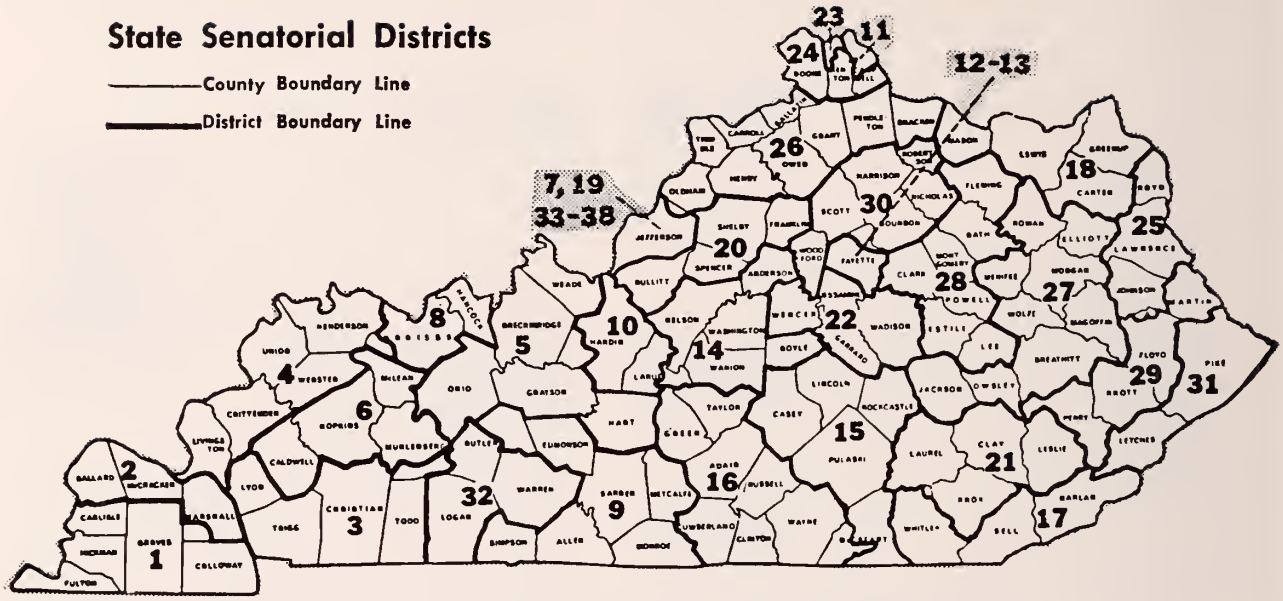
(502) 583-1888



Ky. Senate and House Rosters Listed for 1978 Assembly

A complete list of Senators and Representatives who will participate in the 1978 Kentucky General Assembly is printed below for your information. There are 29 Democratic Senators and 9 Republicans, while the House is composed of 78 Democrats and 22 Republicans.

KENTUCKY GENERAL ASSEMBLY

1978 Senate Roster

District	Senators
1	Richard Weisenberger (D), Moyfield
2	Tom Garrett (D), Paducah
3	Pat McCuiston (D), Pembroke
4	William L. Sullivan (D), Henderson
5	Joe Wright (D), Horned
6	Kenneth O. Gibson (D), Madisonville
7	W. L. Quinlan (D), Louisville
8	Delbert S. Murphy (D), Owensboro
9	Walter A. Baker (R), Glasgow
10	Joseph W. Prather (D), Vine Grove
11	Donald L. Johnson (R), Ft. Thomas
12	Larry J. Hopkins (R), Lexington
13	Michael R. Maloney (D), Lexington
14	H. Edward O'Daniel (D), Springfield
15	John D. Rogers (R), Somerset
16	Doug Moseley (R), Columbia
17	Bert Ed Pollitte (D), Harlan
18	Nelson Robert Allen (D), Russell
19	Tom Mobley (D), Louisville
20	Tom Easterly (D), Frankfort
21	Gene Huff (R), London
22	Robert R. Martin (D), Richmond
23	Gus Sheehan, Jr. (D), Covington
24	Clyde Middleton (R), Covington
25	Lowell T. Hughes (D), Ashland
26	John M. Berry, Jr. (D), New Castle
27	Woodrow Stamper (D), West Liberty
28	John A. Rose (D), Winchester
29	Jim Hammond (D), Prestonsburg
30	Dr. Ed Ford (D), Cynthiana
31	Kelsey E. Friend (D), Pikeville
32	Frank Miller (D), Bowling Green
33	Georgia M. Powers (D), Louisville
34	Jon W. Ackerson (R), Louisville
35	David K. Karem (D), Louisville
36	Eugene P. Stuart (D), Prospect
37	A. D. (Donny) Yocum (D), Louisville
38	Daniel J. Meyer (D), Louisville

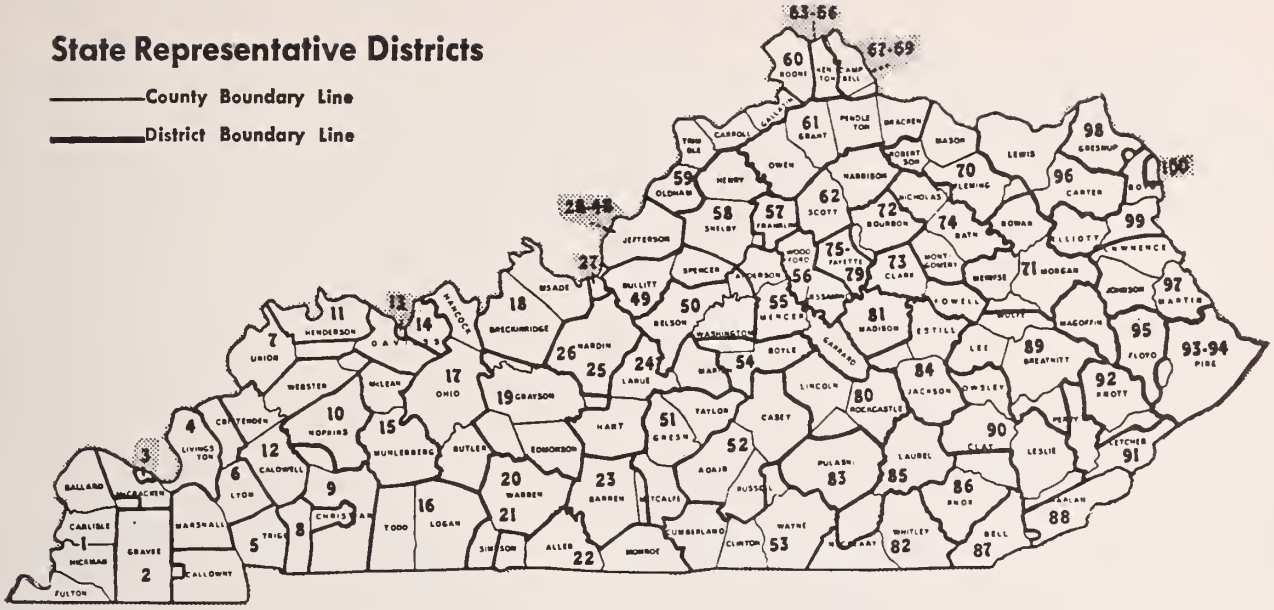
1978 House Roster

District	Representatives
1	Ward Burnette (D), Fulton
2	Lloyd Clapp (D), Wingo
3	Dolly McNutt (D), Paducah
4	J. W. Boatwright, Jr. (D), Paducah
5	Kenneth C. Imes (D), Murray
6	J. R. Gray (D), Benton
7	David E. Boswell (D), Owensboro
8	H. Ramsey Morris, Jr. (D), Hopkinsville
9	James E. Bruce (D), Hopkinsville
10	William T. Brinkley (D), Madisonville
11	Gross C. Lindsay (D), Henderson
12	Joe Head (D), Providence
13	Louis Johnson (D), Owensboro
14	Donald J. Blandford (D), Philpot
15	Philip Stone (D), Central City
16	Lewis Foster (D), Lewisburg
17	Willard (Woody) Allen (R), Morgantown
18	Mary Ann Tobin (D), Irvington
19	Ronny Layman (R), Millwood
20	Jody Richards (D), Bowling Green
21	Buddy Adams (D), Bowling Green
22	Buel E. Guy (D), Scottsville
23	Bobby H. Richardson (D), Glasgow
24	Sam B. Thomas (D), Lebanon
25	Allene A. Craddock (D), Elizabethtown
26	Virgil L. Pearman (D), Radcliff
27	Archie N. Romines, Sr. (D), Valley Station
28	James R. Dunn (D), Pleasure Ridge Park
29	Al Bennett (D), Louisville
30	Thomas J. Burch (D), Louisville
31	Mark D. O'Brien (D), Louisville
32	E. Bruce Blythe, Jr. (R), Louisville

State Representative Districts

County Boundary Line

District Boundary Line



33 Bob Benson (D), Louisville
34 Gerta Bendl (D), Louisville
35 Carl A. Nett (D), Louisville
36 Claudia Riner (D), Louisville
37 M. J. (Jerry) Kleier (D), Louisville
38 Dexter S. Wright (R), Louisville
39 Lawrence Ray Maynard (D), Louisville
40 George R. Siemens, Jr. (D), Louisville
41 Mae Street Kidd (D), Louisville
42 Aubrey Willliams (D), Louisville
43 Carl R. Hines (D), Louisville
44 James B. Yates (D), Shively
45 Dottie Priddy (D), Louisville
46 Harold Haering (R), Louisville
47 Edward L. Holloway (R), Middletown
48 Louis R. Guenthner (R), Louisville
49 Frank J. Smith (D), Shepherdsville
50 John Hurst (D), Bloomfield
51 Herman W. Ratliff (R), Campbellsville
52 Raymond Overstreet (R), Liberty
53 Randolph Smith (R), Monticello
54 Joe Clarke (D), Danville
55 Forest (Aggie) Sale (D), Harrodsburg
56 John V. Carpenter, Jr. (D), Nicholasville
57 C. M. (Hank) Hancock (D), Frankfort
58 W. Stephen Wilborn (D), Shelbyville
59 Robert A. Jones (D), Crestwood
60 William K. McBee (D), Burlington
61 Clay Crupper (D), Dry Ridge
62 Mark Fitzgerald (D), Cynthiana
63 Louis DeFalaise (R), Ft. Mitchell
64 Charles O. Petty (D), Covington
65 John J. Isler (D), Covington
66 Elmer C. Dietz (D), Ludlow
67 Terry L. Mann (D), Newport
68 William Donnermeyer (D), Bellevue
69 Arthur L. Schmidt (R), Cold Spring
70 Pete Worthington (D), Ewing
71 Woodford Mays (D), Woodsbend
72 Jim LeMaster (D), Lexington
73 Paul W. Richardson (D), Winchester
74 Adrian Arnold (D), Mt. Sterling
75 William Gordon Kenton (D), Lexington
76 Steven L. Beshear (D), Lexington
77 David L. Van Horn (D), Lexington
78 John Trevey, M.D. (R), Lexington
79 Henry Clay List (D), Lexington
80 William Harold DeMarcus (R), Stanford
81 Dwight Wells (D), Richmond
82 Elvin Elmer Patrick (R), Williamsburg
83 Marshall Davenport (R), Science Hill
84 Lloyd McKinney (R), McKee
85 Albert Robinson (R), Pittsburg
86 Jimmy White (D), Barbourville
87 George E. Stewart (D), Pineville
88 Roger Noe (D), Harlan
89 John Raymond Turner (D), Jackson
90 Clay Gay (R), Hyden
91 Hoover Dawahare (D), Whitesburg
92 Bill Weinberg (D), Emmalena
93 N. Clayton Little (D), Hartley
94 Herbert Deskins, Jr. (D), Pikeville
95 James (Jitter) Allen (D), Martin
96 George M. Plummer (R), Vanceburg
97 Leo Marcum (R), Inez
98 Ronald R. Cyrus (D), Greenup
99 Ray O. Brown (D), Sandy Hook
100 Charles R. Holbrook, III (R), Ashland

In Memoriam

E. RUDOLPH GERNERT, M.D.
Louisville
1894-1977

E. Rudolph Gernert, M.D., died on December 4 at the age of 83. Doctor Gernert, a thoracic surgeon in practice in Louisville for 56 years until his retirement two years ago, was a 1921 graduate of the University of Louisville School of Medicine. He belonged to the American and Kentucky Thoracic societies and the Jefferson County Medical Society, as well as the American and Kentucky medical associations.

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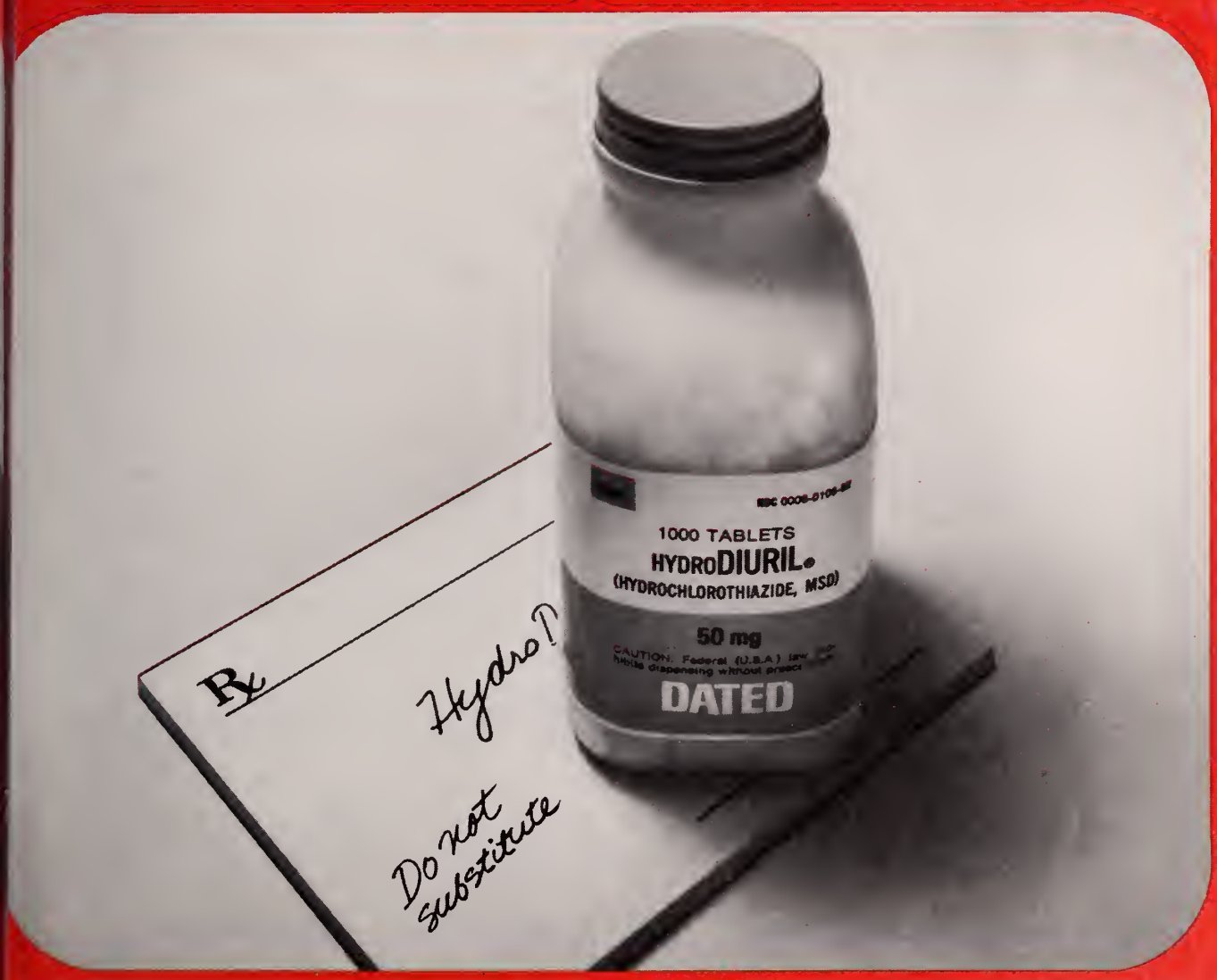
yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.
Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increase ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

airment becomes evident, consider withholding or discontinuing liuretic therapy. Thiazides may decrease serum PBI levels without igns of thyroid disturbance. Calcium excretion is decreased by hiazides. Pathologic changes in the parathyroid gland with hyperalcemia and hypophosphatemia have been observed in a few patients n prolonged therapy; thiazides should be discontinued before testing or parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress ncluding pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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Did you know . . .

The KMA Frankfort Office has been in full operation since the start of the Kentucky General Assembly on January 3. Staffed daily from 8:00 a.m. to 4:30 p.m., the office is located in the Kentucky Chamber of Commerce Building on U.S. 60. The telephone number is (502) 695-4138. In connection with the General Assembly, staff attended the Pre-Legislative Conference held December 2-5 at Kentucky Lake and had the opportunity to meet with and brief state legislators on proposed issues.

* * * *

Written testimony was forwarded by KMA to the Office of Planning Evaluation and Legislation, Health Resources Administration, Department of HEW, on proposed national guidelines for health planning. The regulations would seek to impose guidelines that would possibly supercede not only the first level planning groups established by current law, but also the Health Systems Agencies and the state government agencies that are supposed to provide current guidelines.

Members in the news

NEW MEMBERS

CAMPBELL-KENTON
Artemio S. Medina, Jr., M.D., Ft. Mitchell

FAYETTE
C. Patrick Beatty, M.D., Lexington
Elvis S. Donaldson, M.D., Lexington
L. Alan Drake, M.D., Lexington
Terence L. Gutgsell, M.D., Lexington
Christa Muckenhausen, M.D., Lexington
John E. Pappas, M.D., Lexington
Anthony Suruda, M.D., Lexington
Ernest T. Wightman, Jr., M.D., Lexington

HENDERSON
Mary L. Harrison, M.D., Henderson

JEFFERSON
Carl Wolf, M.D., Louisville

McCRACKEN
Ben H. Taylor, M.D., Paducah

KMA Provides Placement Service to Physicians, Communities

Perhaps you have just completed your internship, residency, or have some other reason for needing to make a change. Perhaps you are a physician in practice and need an associate or replacement. If so, the KMA Physicians Placement Service is available to help you.

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish a practice, to relocate, or to help established physicians find associates.

A semiannual listing of "Opportunities for Practice in Kentucky" is published by the Placement Service. This report lists over 100 areas in Kentucky that need family practitioners either in association with another physician or as a replacement. The Service maintains a similar listing of areas in need of medical specialists. Opportunities for partnership or group practice are also listed and requests are accepted from both physicians and communities for satisfactory placement.

As an additional service the KMA Physicians Placement Service also publishes "Physicians Seeking Locations," a quarterly listing. This is compiled from data received from the American Medical Association, requests from recipients of the Rural Kentucky Medical Scholarship Fund, interns and residents in Kentucky, and personal inquiries to the KMA office.

It is the policy of the Placement Service to provide a two-way flow of information between interested parties, rather than try to "place" physicians in the "right" practice situation.

Inquiries may be addressed to the Physicians Placement Service, Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

Headquarters Activity

DECEMBER

2-5	Pre-Legislative Conference, Kentucky Lake
3-7	AMA Interim House of Delegates Meeting, Chicago
6-8	FLEX Exams, Louisville
8	Claims and Utilization Review Committee, Louisville
	Ad Hoc Committee on Professional Liability, Louisville
12	*Journal* Editors, Louisville
13	KMA-KNA Joint Practice Committee, Louisville
14	Judicial Council, Louisville
	HSA-East Plans and Development Meeting, Winchester
	Specialty Group Presidents Meeting, Louisville
	McDowell House Board of Managers, Danville
14-15	KMA Board of Trustees, Louisville

JANUARY

3	1978 Kentucky General Assembly Convenes, Frankfort
4	Interspecialty Council on Insurance, Louisville
3-7	Professional Convention Management Association, San Antonio
9	*Journal* Editors, Louisville
12	Membership and Placement Services Committee, Louisville
18	Cancer Committee, Louisville
19	Board of Medical Licensure, Louisville
26	Blue Cross-Blue Shield Board, Louisville
26-29	AMA Leadership Conference, Chicago
31	Auxiliary Legislative Day, Frankfort

Malpractice Insurance

As one of Kentucky's largest insurance agencies with more than 60 years of providing Kentuckians with professional service, we are pleased to announce to the physicians of Kentucky, that we now represent the Insurance Corporation of America.

I.C.A. is an approved surplus lines company, managed by attorneys and physicians who understand the problems of malpractice insurance. The policies issued by I.C.A. are on an occurrence basis for 100,000/300,000, either primary or excess. The rates are low and are based on Kentucky's malpractice history rather than that of the country as a whole.

We believe that I.C.A.'s policies may be of particular interest to the physician who now needs coverage above the primary 100,000/300,000 policy which he carries through his regular sources.

We also have the expertise to solve other possible malpractice problems and we welcome your inquiries.

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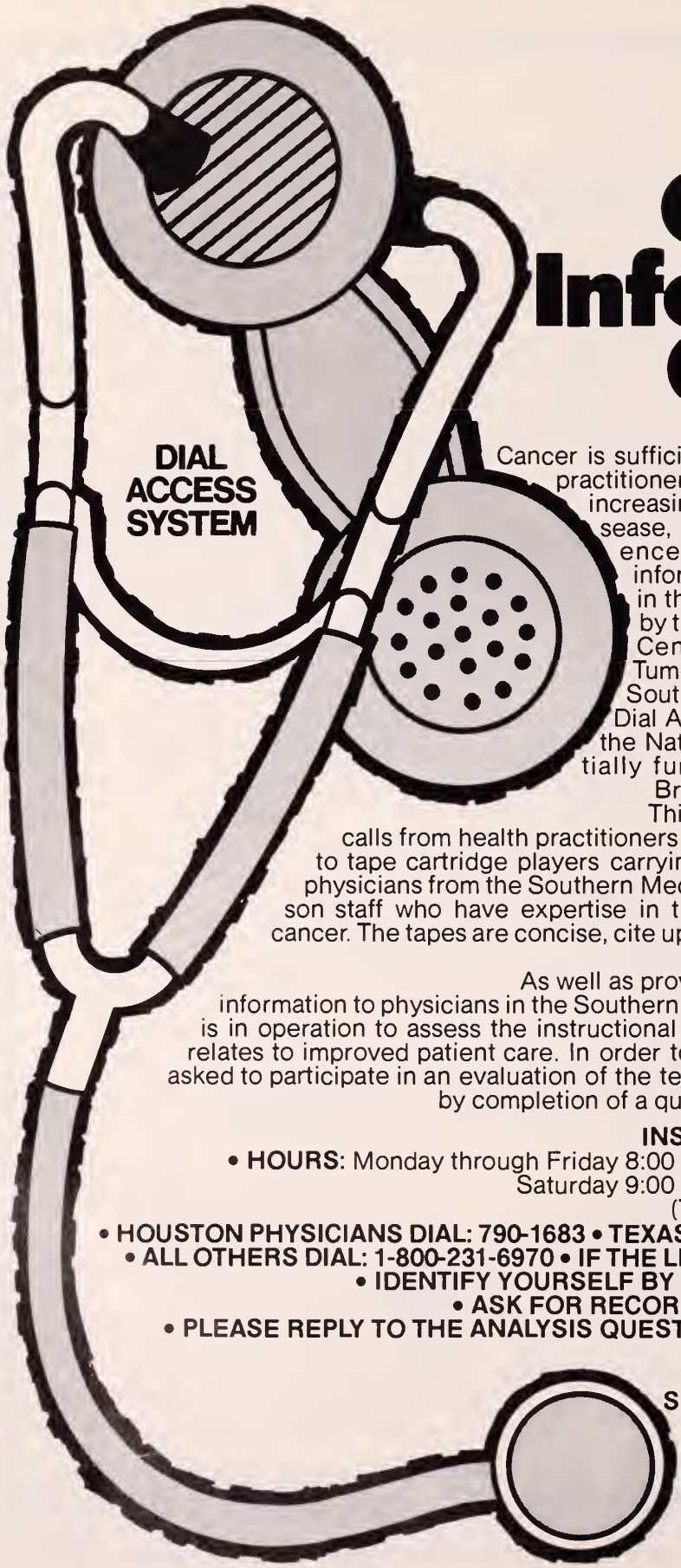

SMA Cancer Information Center

Cancer is sufficiently prevalent that it touches every practitioner directly or indirectly. To facilitate the increasingly complex management of this disease, an easily accessible source of reference data is needed. This much-needed information is being supplied to physicians in the Southern Medical Association area by the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute, in cooperation with the Southern Medical Association. Known as Dial Access, this system is an outgrowth of the National Cancer Act of 1971 and is partially funded through the Cancer Control Branch of the National Cancer Institute.

This system provides toll-free telephone calls from health practitioners in all 17 states through 5 WATS lines to tape cartridge players carrying some 350 narrations authored by physicians from the Southern Medical Association and the M.D. Anderson staff who have expertise in the management of various types of cancer. The tapes are concise, cite up to three references, and have author identification.

As well as providing cancer management reference information to physicians in the Southern Medical Association area, the project is in operation to assess the instructional value of this and similar systems as relates to improved patient care. In order to accomplish this last, callers will be asked to participate in an evaluation of the technique and information transmitted, by completion of a questionnaire mailed to first-time users.

INSTRUCTIONS FOR USE OF SYSTEM

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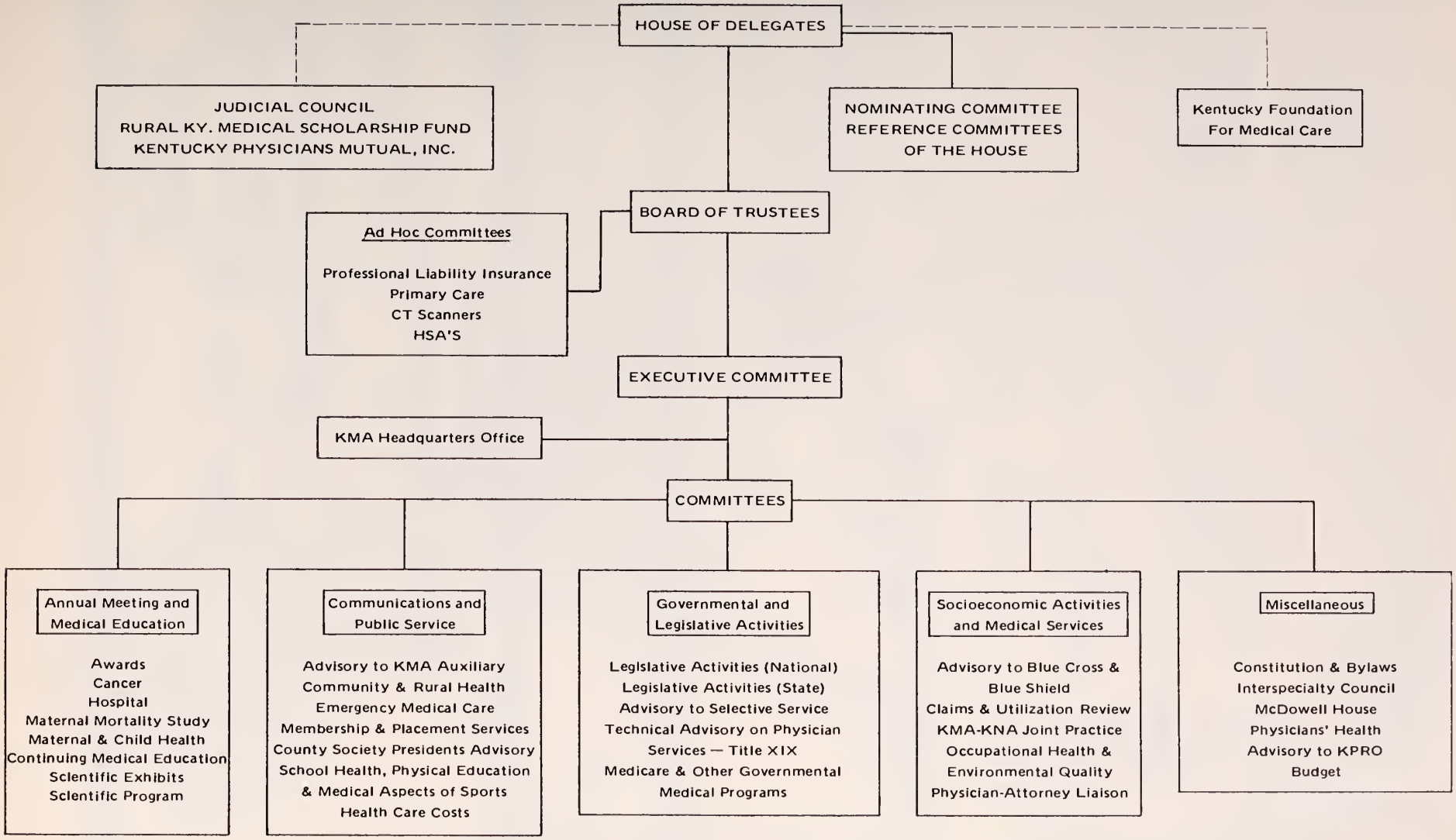

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Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.
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Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.
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Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.
Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

February 1978
Volume 76
Number 2

Metastasizing Carotid Paragangliomas,
Brachial Plexus Mnemonic and
Gallbladder Ultrasound Evaluation Discussed

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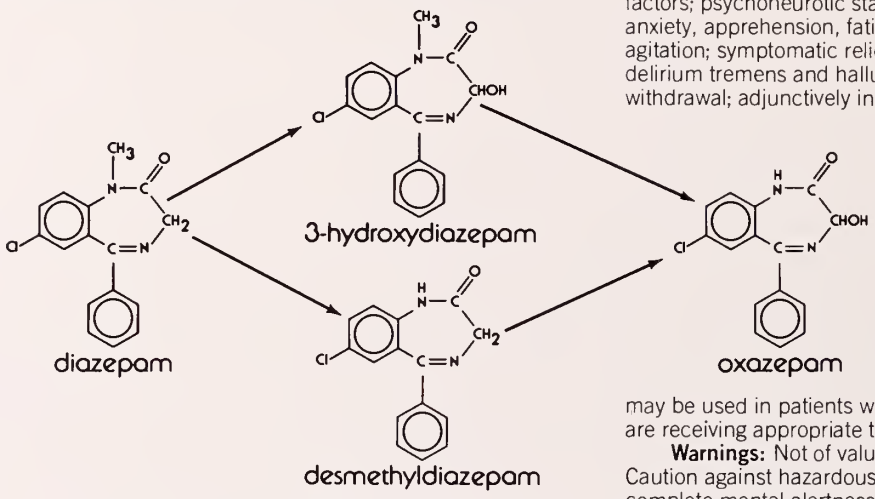
MDS

The Journal Of The Kentucky Medical Association

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

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Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MESSAGE FROM THE PRESIDENT

Relentless Government Growth

THIS nation grew great because of freedom, maximum individual freedom and minimum government regulation. Economic motivation released individual enterprise.

The history of the world is the history of economics. The great civilizations of the world began with economic enterprise, expanded for purposes of trade, and blossomed in arts and letters with the affluence that followed. Most of the great wars in history were fought for economic reasons—to expand trade or protect empires.

Our government grows by establishing monopolies through its power of licensure and then develops enormous bureaucracies to regulate those monopolies. At one time, the railroads were efficient and competitive—today government franchises exclusive routes, and regulates fees allowing inadequate profit for maintenance and new equipment. The result—inefficient service and high accident rates. The ultimate loser is the consumer—choice is restricted, the benefits in price and service from competition are destroyed, and taxation is increased to fund the bureaucrats. Look at health today—the power of licensure, "the certificate of need", grants exclusive territorial rights to a hospital. The next step is legislation to regulate prices. Then will follow the inexorable growth of bureaucracy to regulate health. There is now talk of a certificate of need for physicians' private offices.

Historically, with the exception of the Civil War, prior to World War I, the sum total of federal, state, aand county taxes never exceeded 10% of the gross national product. Today federal, state, and county taxes are 40% of the gross national product. A large percentage of this goes to welfare—a system that rewards no work, while enterprise and productivity are penalized by confiscatory taxation. The progressive income tax is the key. As inflation raises incomes, the percentage taken by the government increases. This system funds the growth of government. Inflation is assured by excessive federal deficits as new money is printed to fund those deficits. The federal debt—$600 billion in 1976, passed $700 billion in 1977.

This nation began because of oppressive regulation and excessive taxation by a foreign power. Today that power is Washington. I ask, "Is it time for another Boston Tea Party?" We don't need guns, you know—we have the power of the vote.

John P. Stewart, M.D.
President, Kentucky Medical Association

POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

FEBRUARY

14 "Recent Advances in Diagnosis of Portal Hypertension**," Louisville Area CME Consortium, St. Anthony Hospital, Louisville

19-24 Eighth Family Medicine Review*, Session III, 50 hrs. AAFP, Category I-AMA Physician's Recognition Award, Fee: $295, Hyatt Regency Hotel, Lexington

23-24 Breast Cancer Symposium**, Galt House, Louisville

24-25 Fourth International Symposium on Psychopharmacology, University of Louisville Health Sciences Center, (11 prescribed credit hours) Louisville

MARCH

1 "Microvascular Surgery**," Louisville Area CME Consortium, Health Sciences Center, Louisville

10 C. Dwight Townes Memorial Seminar**, University of Louisville Health Sciences Center, Louisville

10-11 Kentucky Chapter, American College of Surgeons, Hyatt Regency Hotel, Lexington

11 "Developments in the Treatment and Care of Patients with Head and Neck Cancer," University of Louisville Health Sciences Center Auditorium, Louisville

22 "The Mitral Valve Complex and its Disorders**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29 "Burn Treatment**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29-30 Twenty-fourth Annual Symposium on Cardiovascular Diseases, University of Louisville Health Sciences Center, Louisville

APRIL

6 Twenty-third Annual Spring Clinical Conference, Lexington Clinic, Lexington

12 "Interplay of X-ray and Endoscopy on Gastroenterology**," Louisville Area CME Consortium, St. Joseph Infirmary, Louisville

14-15 "Diabetes Control: Why and How*," University of Kentucky, Hyatt Regency, Lexington

20-22 "High Risk Pregnancy**," University of Louisville, Executive West, Louisville

24-27 Postgraduate Course in Surgical Anatomy**, Health Sciences Center, Louisville

28-May 1 Fourth Annual Postgraduate Course in Surgery, University of Louisville, Galt House, Louisville

For further information, contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, University of Kentucky College of Medicine, Lexington 40506

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13-15 "The Infertile Female," University of Tennessee Center for the Health Sciences, Holiday Inn Rivermont, Memphis. Contact: Division of Continuing Education, U.T.C.H.S., 800 Madison Ave., Memphis, Tenn. 38163.

22-24 "Clinical Endocrinology," sponsored by the American College of Physicians, Nashville. Contact: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

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John L. Wolford, M.D., Chairman

UNIVERSITY OF LOUISVILLE HEALTH SCIENCES CENTER

Wednesday, March 29, 1978

8:30-9:00 a.m. REGISTRATION

WELCOME — Henry W. Post, M.D., President

MORNING SESSION—
Terry W. Henkel, M.D., Presiding
"CARDIAC REHABILITATION"

9:00 — **"Physiology of Exercise"**
BRYANT STAMFORD, Ph.D., Director of Exercise, Physiology Laboratory, University of Louisville

9:35 — **"Cardiac Rehabilitation Through Physical Exercise—Early Phase"**
GERALD FLETCHER, M.D., Director of Internal Medicine, Georgia Baptist Medical Ctr., Professor of Medicine, Emory University School of Medicine

10:20 — COFFEE BREAK

10:40 — **"Cardiac Rehabilitation Through Physical Exercise—Long Term Approach"**
ROBERT ROBERTSON, Ph.D., Director of Human Energy Research Lab, University of Pittsburgh

11:20 — **"The Prognosis of Coronary Artery Disease—1978"**
GOTTLIEB FRIESINGER, M.D., Professor of Medicine; Director, Division of Cardiology, Vanderbilt University School of Medicine

12:00 — **Grand Rounds U/L Health Sciences Center**
Moderator: DANIEL E. McMARTIN, M.D., Assistant Professor of Medicine, Assistant Chief of Cardiology, University of Louisville School of Medicine

1:00 — LUNCH

AFTERNOON SESSION—
Harold D. Haller, M.D., Presiding

2:00 — **"Echocardiography for the Practicing Physician"**
EMILIO GIULIANI, M.D., Mayo Clinic

2:40 — **"Exercise Testing, Values and Limitations"**
GERALD F. FLETCHER, M.D.

3:20 — **"Echocardiography for the Practicing Physician—Newer Concepts"**
EMILIO GIULIANI, M.D.

4:00 — **"Myocardial Imaging"**
GOTTLIEB FRIESINGER, M.D.

Thursday, March 30, 1978

8:30-9:00 a.m. REGISTRATION

MORNING SESSION—
Franklin B. Moosnick, M.D., Presiding
"LIMITATIONS OF MYOCARDIAL INFARCTION SIZE"

9:00 — **"Newer Physiologic and Electrophysiologic Monitoring Techniques in the Management of the Patient with Acute Myocardial Infarction"**
JAMES D. MALONEY, M.D., Mayo Clinic

9:40 — **"Pharmacologic Control of Myocardial Infarction Size"**
HERMAN K. GOLD, M.D., Massachusetts General Hospital in Boston

10:20 — COFFEE BREAK

10:40 — **"Pharmacologic Control of Myocardial Infarction Size" (continued)**
HERMAN K. GOLD, M.D.

11:20 — **"Cardiogenic Shock"**
JAMES D. MALONEY, M.D.

12:00 — THE BERNARD D. ROSENBLUM MEMORIAL LECTURE
"Dynamics of Recent Technicological Advances in the Field of Cardiac Electrical Activity"
AGUSTIN CASTELLANOS, M.D., Professor of Medicine, Division of Cardiology, University of Miami School of Medicine

1:00 — LUNCH

AFTERNOON SESSION—
John L. Wolford, M.D., Presiding

2:00 — **"Differential Diagnosis of Refractory Ventricular Arrhythmias"**
PAUL TROUP, M.D., Kannert Institute of Cardiology; Indiana University School of Medicine

2:40 — **"Clinical Application Epicardial of Mapping"**
JOHN P. BOINNEAU, M.D., Professor of Medicine, Chief of Cardiology, Veterans Hospital, Augusta, Ga.

3:20 — **"Newer Antiarrhythmic Drugs, Values and Limitations"**
PAUL TROUP, M.D.

This course has been approved for 11 hours credit towards Category I of the AMA Physicians Recognition Award—AHA Council on Cardiology; and the University of Louisville School of Medicine; acceptable for 11 hours by the American Academy of Family Physicians.

REGISTRATION: Physicians $30 pre-registration; $35 desk registration; Nurses $10; Medical Students and House Staffs —No charge.

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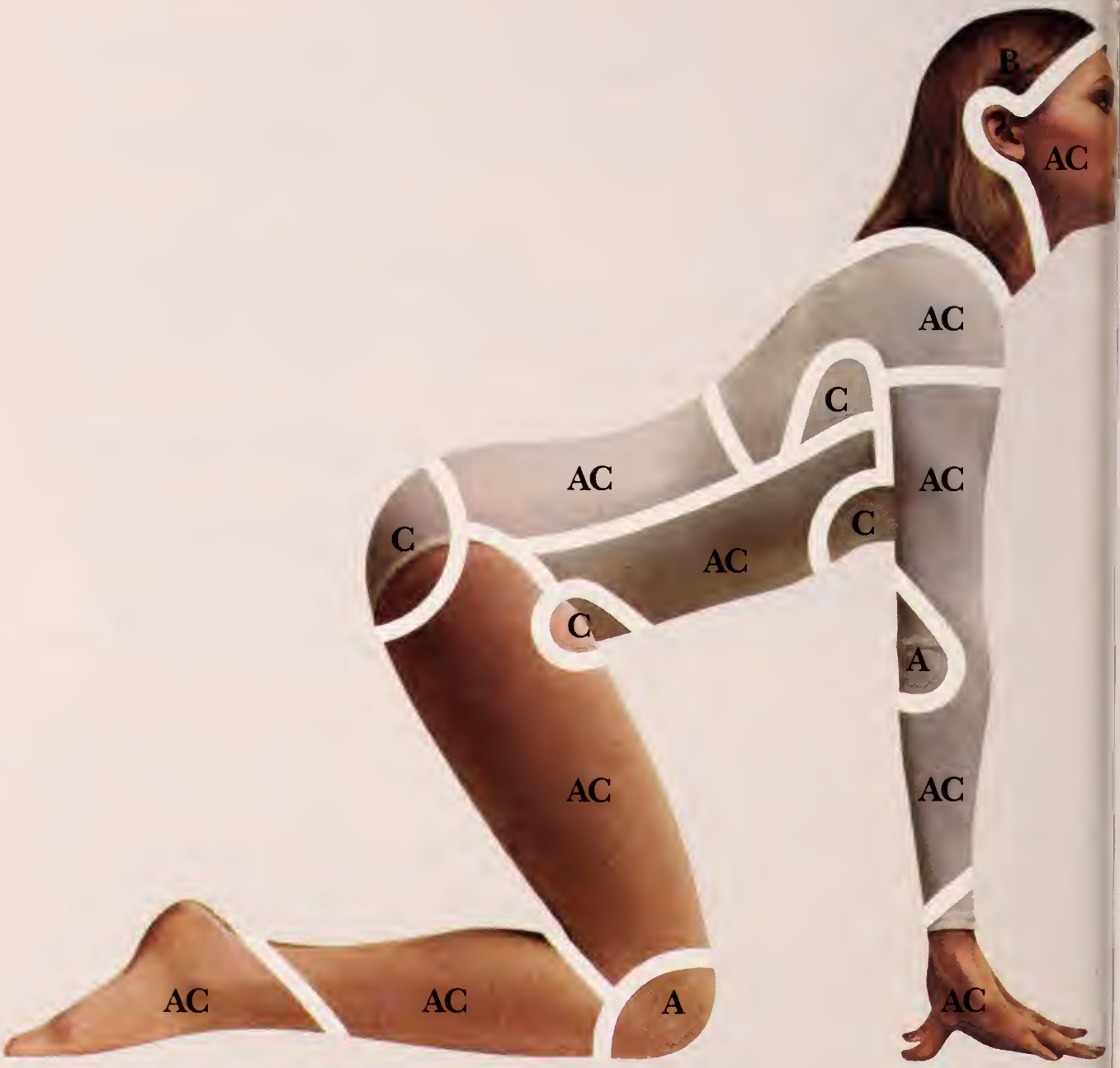

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*Majority of patients evaluated after 2 weeks' therapy. Data on file at Squibb Institute for Medical Research.

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Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids; their extensive use increases the possibility of systemic effects. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. The patient should be kept under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Use of the occlusive dressing should be discontinued if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.
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The JOURNAL of the
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VOLUME 76 FEBRUARY 1978 NUMBER 2

Metastasizing Carotid Paragangliomas

Samuel A. Smith, M.D.; James Kuhns, M.D., and Gorden T. McMurry, M.D.

Louisville, Kentucky

Benign tumors of the carotid body are uncommon, and the malignant variety is decidedly rare. The diagnosis may be complex. Two patients with metastasizing carotid paragangliomas are presented, with a discussion of diagnosis, disease process, and treatment.

CAROTID body tumors are uncommon: just over 500 benign tumors and 40 malignant tumors have been reported in the world literature.[1] In addition to a paucity of reports, the nomenclature is confusing. Among the terms used to describe such tumors are carotid body tumor, nonchromaffin paraganglioma, and paraganglioma. Carotid paraganglioma probably is most correct, because (1) the exact anatomic location is stated; (2) electron microscopy has disclosed neurosecretory granules in the chief cells of the carotid body and its tumors; (3) formalin-induced fluorescence characteristic of catecholamine storage has been noted; (4) the origin of these structures is the neural crest; and (5) some of these tumors have shown endocrine function but negligible chemoreceptor activity.[2-4]

Carotid bodies and tumors arising from them are considered members of the APUD (Amine content, Precursor Uptake, and Decarboxylation) system described by Pearce.[2] In general, members of this system produce hormones; more specifically, the carotid body and some of its tumors manufacture catecholamines.[2,4]

Although the exact pathways have not been elucidated fully, compensatory changes in cardiopulmonary function occur in response to an abnormal milieu in the carotid body which includes decrease of the arterial oxygen tension, increased acidity, and increased carbon dioxide tension in the blood.[5]

Case Reports

Case #1: In April, 1962, a 52-year-old woman was admitted with a history of weakness of both lower extremities for the past year. She had had difficulty walking which progressed to paralysis of the lower extremities. Physical examination disclosed a mass measuring 5 x 8 cm in the left neck. The patient stated it had been present for 25 to 30 years and had slowly enlarged. Spastic paralysis and sensory distortion were present in both lower legs. Myelogram showed a mass lesion compressing the spinal cord in the region of the fifth, sixth, and seventh thoracic vertebrae. Shortly thereafter she underwent thoracic laminectomy, at which time a bluish vascular tumor mass was removed from the epidural space. Tissue examination was consistent with a paraganglioma.

In June, 1962, after the patient underwent carotid arteriograms, an open biopsy of the neck mass was performed and a diagnosis of carotid paraganglioma was made. The patient's treatment consisted of 3,494 rads to the neck mass.

Repeated urinary tract infections and renal and

Reprint requests to Samuel Smith, M.D., Department of Pathology, University of Louisville School of Medicine, Health Sciences Center, Louisville, Kentucky 40201. Doctor Smith is a Clinical Fellow of the American Cancer Society in the Department of Pathology. Doctors Kuhns and McMurry are from the Departments of Pathology and Surgery, respectively, of the University of Louisville School of Medicine and Norton-Children's Hospitals, Louisville.
Received at KMA: 9-12-77.

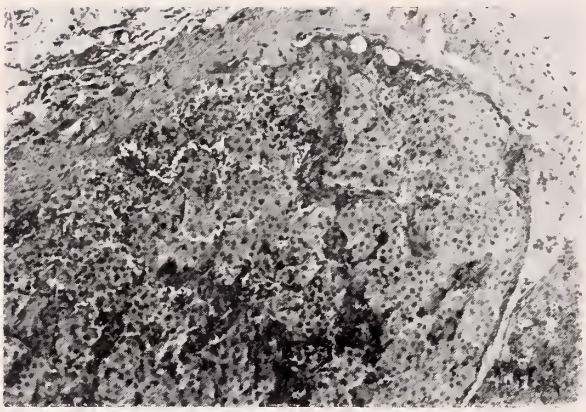

FIG. 1. The typical basket-like arrangement of cells surrounded by fibrous trabeculae and prominent vascular changes is seen in a specimen from the first patient (hematoxylin-eosin, x 110).

urinary bladder lithiasis characterized the post-irradiation course. She died of sepsis in April, 1964. No autopsy was performed.

Case #2: A 61-year-old woman was first seen in March, 1976, complaining of hoarseness of four months' duration. She noted weakness of the right shoulder, intermittent episodes of weakness of the right arm, and weakness of the tongue. The patient also complained of episodes in which she "passed out," which were relieved by recumbency. She had noticed some unsteadiness of gait but denied changes in hearing. Physical examination disclosed atrophy of the right side of the tongue and right trapezius muscle. She had a coarse voice with air escape, paralyzed right vocal cord, and bilateral neck masses. The right mass extended from approximately the level of the carotid bifurcation to the angle of the mandible. A bruit was present. On the left, a 3 x 4 cm mass was situated in the vicinity of the carotid bifurcation. An audiogram demonstrated a 20-decibel hearing level bilaterally through the speech frequencies, with 96% discrimination scores.

Arteriography showed a hypervascular tumor extending from the bifurcation of the right common carotid artery superiorly for 7 cm to the base of the skull but not entering the jugular bulb. It appeared to be supplied by several of the external carotid branches, specifically the occipital postauricular, the ascending pharyngeal, and probably branches from the sphenopalatine artery. Shunting was apparent into the right internal jugular vein and smaller posterior veins. A selected right internal carotid arteriogram disclosed forward displacement of that artery with concentric narrowing of its extracranial portion, suggesting encasement. The right external carotid artery was displaced anteriorly, and a 3 x 3 x 2 cm vascular tumor extended from the right carotid bifurcation into the right external carotid artery. These findings were considered typical of a carotid paraganglioma.

The patient underwent operation in March, 1976, in which the right-sided mass was resected through a transmastoid, extended facial recess approach, with neck dissection and exposure and packing of the jugular foramen. Because of the circumferential involvement of the internal carotid artery and the tumor's extension to the base of the skull, complete removal was doubtful.

Seventy-two hours after operation, the patient developed progressive facial nerve paralysis. A diagnosis of malignant carotid paraganglioma with metastatic spread to a lymph node was made, and the patient underwent right radical neck dissection in June, 1976. Two additional nodes with metastatic disease were discovered at Level II. Three months later the patient's facial nerve function returned to normal; at 9 months there was no further evidence of metastatic dissemination.

Pathologic Findings

The biopsy specimen of patient #1 demonstrated the typical basket-like arrangements of chief cells in pseudoalveolar clumps. The chief cells had moderate-to-marked variability in size and pleomorphism of the nuclei. The cytoplasm, for the most part, was clear to slightly eosinophilic (Fig 1 and 2). There was dilation of thin-walled vessels within the tumor and occasional granules of hemosiderin were noted.

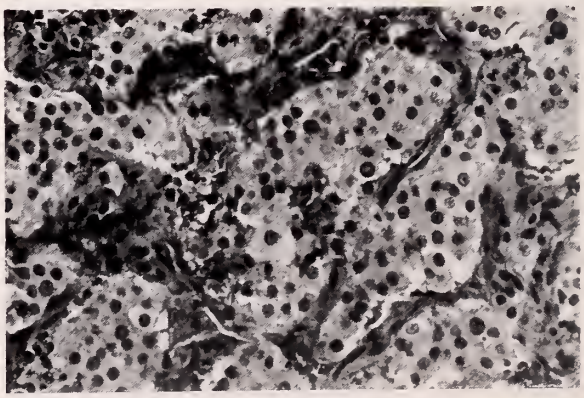

FIG. 2. Increased magnification of Fig 1 shows the pleomorphic chief cells comprising a zeballen (hemotoxylin-eosin, x 340).

In the second case the excised lesion was 5 x 2 x 1.8 cm with hemorrhagic, purplish-red discoloration. On sectioning, a variable tan-to-hemorrhagic tissue coursed by fine fibrous trabeculations was noted. The tumor mass was accompanied by two lymph nodes, one of which had an irregular 1 to 2 mm pale tan focus.

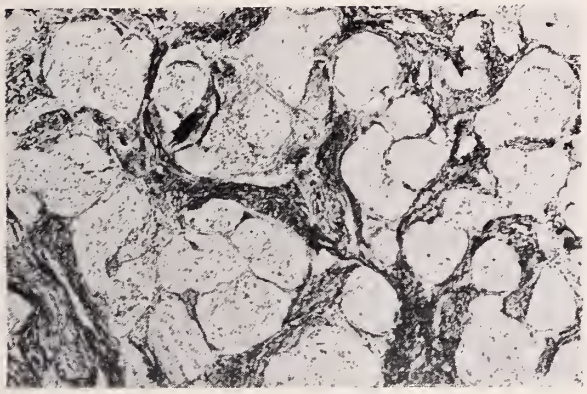

FIG. 3. The reticulum stain of tissue from the second patient demonstrates the fibers surrounding each nest of chief cells (x 55).

On microscopic examination, the typical arrangement of chief cells in pseudoalveolar clumps surrounded by hypocellular fibrous trabeculations was seen. This pattern was accentuated with reticulin stain (Fig 3). Individual cells had moderate-to-marked variability with pale, clear to moderately dense eosinophilic cytoplasmic processes. The nuclei were nonuniform. Occasionally bizarre nuclei were seen with some tendency toward lobulation and marked hyperchromasia. Mitotic figures were sparse. Metastatic disease was present in the previously described lymph node with the irregular focus (Fig 4).

Electron microscopy showed the tumor cells arranged in alveoli surrounded by connective tissue with an abundant blood supply. Individual tumor cells varied greatly in size with a few cellular interdigitations or desmosome-like structures. The tumor cells in the alveoli were not separated from the connective tissue by a continuous basal lamina. They contained a variable number of round, electron-dense granules, each of which was composed of an electron-dense core surrounded by a small clear halo and unit membrane (Fig 5). The granules had diameters of 0.1 to 0.15 microns. The cytoplasm also contained a variable amount of small round to oval mitochondria, profiles of rough and smooth endoplasmic reticulum, and one or more Golgi complexes. Infrequent unmyelinated nerve endings were present in the tumor cells, which were haphazardly entrapped in thin cell extensions of what appeared to be sustentacular cells. This layer was incomplete and portions of the underlying tumor cells were exposed to the interstitial tissue. A dark chief cell with abundant angulated granules was not encountered in the specimen. Vascular structures and pericytes were surrounded by a normal basal lamina. In the connective tissue surrounding the tumor cells there were many fibroblasts, collagen, and elastic fibers.

Discussion

Reviews of the literature on carotid paragangliomas undertaken by Staats and associates in 1966,[6] Tu and Bottomley in 1974,[1] and the case presentations by Martin and colleagues in 1973[7] catalog approximately 500 carotid paragangliomas, including 40 malignant ones (7%). Bilaterality of carotid paragangliomas as noted by Sugarbaker and co-workers[8] varied from 2.8% to 5% in nonfamilial, sporadic cases to nearly 30% in familial occurrences.

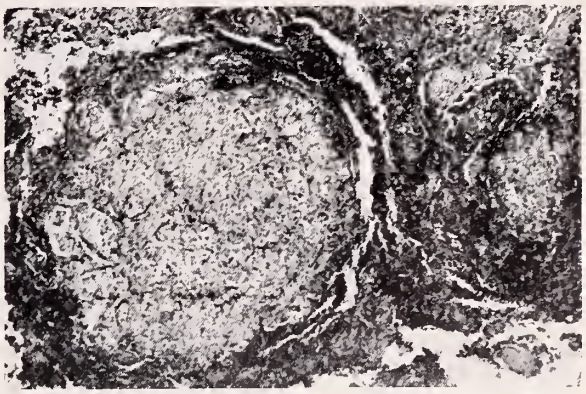

FIG. 4. Metastatic carotid paraganglioma is seen within a lymph node from the second patient (hematoxylin-eosin, x 55).

Most carotid paragangliomas are adherent to surrounding tissue, show little local invasion,[9] and behave clinically in a benign fashion. Although the tumors have been divided into histologic varieties by LeCompte,[10] malignant potential cannot be determined microscopically.[11,12] The use of standard pathologic criteria, including mitoses, giant cell forms, and nuclear pleomorphism, leads to confusion in the prediction of the tumor behavior.[13] The most common manifestation of malignancy may be recurrence following excision,[9] although this may represent residual tumor overlooked at initial surgical therapy.

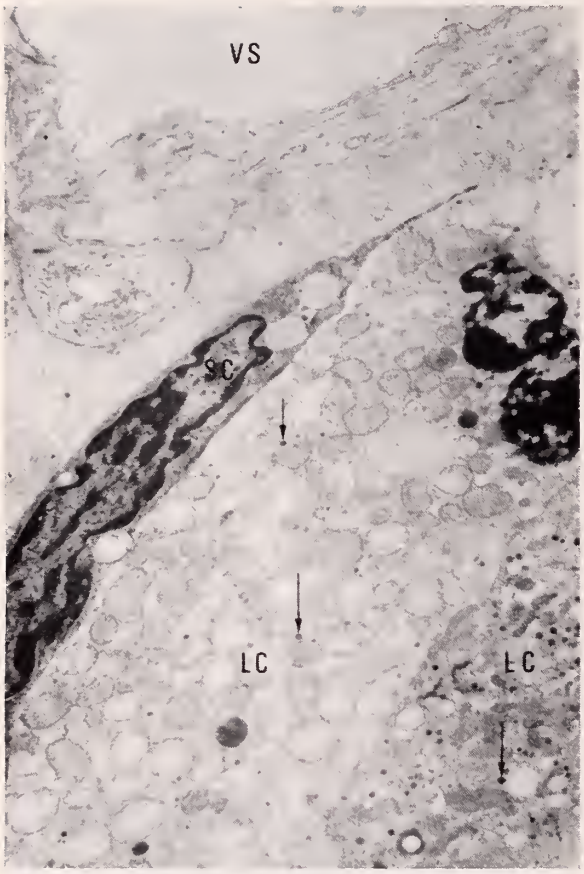

FIG. 5. Electron micrograph from the second patient. At the top of the picture is a vascular space (VS) surrounded by endothelial cells and pericytes. Two light cells (LC) are noted underneath, containing variable numbers of secretory granules (arrows). The light cells are partially surrounded by a sustentacular cell (SC) (x 4000).

Paragangliomas may be found in the head and neck as well as the thoracic and abdominal cavities. The question of metastases versus a multicentric origin secondary to a common defect resulting in a common systemic response has been raised by Conley.[14] The existence of the so-called "pulmonary chemodectoma" is made doubtful by the extensive study of Kuhn and Askin.[15] Most investigators, however, believe that the tumor is capable of metastasis, and the finding of a metastatic site establishes the diagnosis of malignancy.[9,11,13]

To date, there have been 20 reported cases of carotid paragangliomas giving rise to distant metastases.[1,7] Lung and bone are the most common sites of dissemination, although metastases have been found in the liver, pancreas, thyroid, heart, trachea, orbit, epidural space, breast, and kidney.[1,16] Patient 1 represents the 21st case with distant metastasis to the epidural space. The epidural space is not part of the normal adult distribution of neurocrest derivatives,[17] although paraganglia cells may migrate through it during embryologic development in order to reach their final locations.

Sixteen patients with nodal metastases were reviewed by Tu and Bottomley,[1] Staats and coworkers and found a single patient,[6] and Martin and associates[7] described three others; Patient 2 becomes the 21st reported example of this disease entity. At the time of initial operation, a single node was found to contain a focus of metastatic tumor. The nodal capsule was intact, and direct extension from the primary lesion was not evident. At radical neck dissection, 2 of 23 nodes were largely replaced by tumor. Because paraganglia cells are not normally constituents of lymph node tissue,[17] the finding of such cells replacing the parenchyma must be considered evidence of metastatic disease.

As a result of the rarity of malignant carotid paragangliomas and the limited follow-up of patients, the natural history is uncertain.[11] Metastatic lesions may manifest themselves long after the primary tumor is excised.[18,19] Lengthy, symptom-free survival is possible even in the presence of dissemination.[1] However, the tumor may cause death by direct extension into vital structures or by dissemination.[19-21]

Patients with non-metastasizing disease are treated with radiation therapy,[22] operation,[23,24] or a combination of these modalities.[25,26] In small lesions which are readily resectable and which bear no evidence of metastases, primary en bloc resection is probably the treatment of choice. In large lesions with either metastatic spread or a high index of suspicion of metastasis and in lesions which are not totally resectable without sacrificing vital structures, surgical resection with either pre- or post-operative irradiation of 4,000 to 5,000 rads comprises the treatment of choice. In lesions which are completely nonresectable because of extensive bony or soft tissue involvement, radiation therapy is indicated. The role of chemotherapy for inoperative and metastatic disease has not yet been evaluated adequately.

Acknowledgement

Per H. B. Carstens, M.D., has supplied the electron microscopic description and micrographs utilized in this report.

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A "Five-Fingered" Mnemonic for the Brachial Plexus

David Peck, Ph.D.

Lexington, Kentucky

A mnemonic is presented whereby five fingers are positioned so that the brachial plexus organization and its relation to the axillary artery may be visualized.

ANTERIOR primary rami of five spinal nerves constitute the roots from which the brachial plexus is formed by a series of alternating unions and bifurcations. The organization of the plexus can be visualized by placing the five fingers of your hand in five sequentially ordered positions, using each position to represent an important structural feature of the plexus. The nomenclature and proximo-distal sequence of the alternating unions and bifurcations are easily remembered by the commonly used mnemonic "Robert Taylor Drinks Cold Beer" (roots, trunks, divisions, cords, and branches).

To obtain maximum benefit from the mnemonic presented, it is strongly recommended that a crude sketch of the plexus be drawn while positioning the fingers in sequence as a guide to the organization of the plexus.

Figure #1 illustrates that the anterior primary rami of 5 spinal nerves form the roots of the brachial plexus. This initial positioning of all five fingers also shows that C5, the fifth cervical spinal nerve, is the most superior or cranial contribution to the plexus.

It is useful to remember that C5 makes a significant contribution to the phrenic nerve and therefore an ipsilateral hemidiaphragm paresis may accompany traction lesions of the brachial plexus involving the upper roots. The sympathetic outflow to the head is from the T1 root and therefore an ipsilateral Horner's syndrome accompanies lesions of this root. In addition, the long thoracic nerve to the serratus anterior arises from roots, and "winging" of the ipsilateral scapula may therefore accompany lesions involving the C5, C6, and C7 roots.

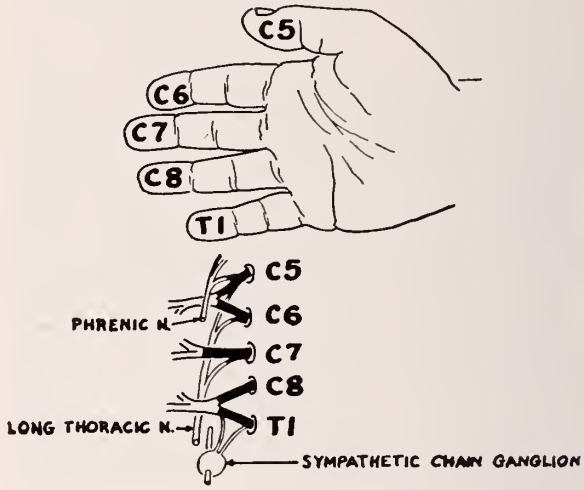

FIG. 1 Positioning of the fingers to illustrate the spinal nerves which contribute roots to the brachial plexus.

The positioning of your fingers in Figure #2 represents the union of the roots to form three trunks: upper, middle, and lower. The middle finger represents the middle trunk and thus indicates that this trunk arises from the C7 root. Similarly, the roots which form the upper and lower trunks may also be recalled by simply counting the fingers representing them.

The suprascapular nerve to the supraspinatus and infraspinatus muscles arises from the upper

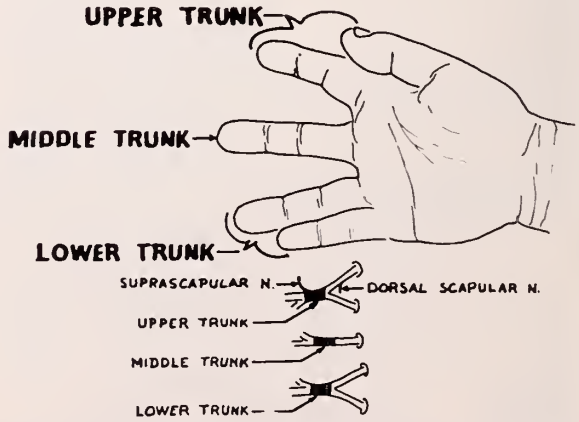

FIG. 2 Positioning of the fingers represent union of roots to form the trunks of the brachial plexus (note the middle finger represents the middle trunk).

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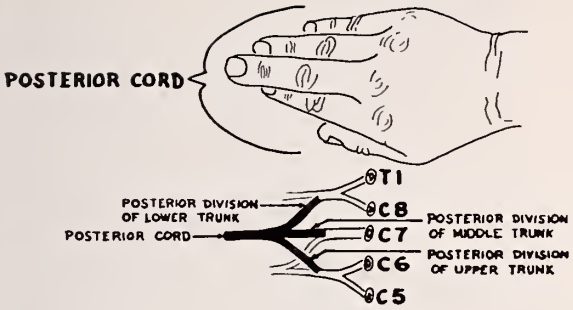

FIG. 3 Posterior view of the positioning of all five digits to represent union of posterior divisions of trunks forming the posterior cord.

trunk. Loss of ability to externally rotate the humerus indicates lesions in, or proximal to, this nerve. The dorsal scapular nerve to the rhomboid muscle usually arises from the C5 root, and inability to retract the scapula indicates a lesion in or proximal to this nerve.

Each of the three trunks bifurcates into an anterior and a posterior division. These divisions unite to form the cords of the brachial plexus. The positioning of the fingers in Figure #3 shows that the posterior divisions of all three trunks (and therefore contributions from all five roots) unite to form the posterior cord.

The branches, i.e. the nerves, which arise from the posterior cord innervate the posterior musculature of the extremity. In general, the posterior cord controls posterior motions of the joints of the superior extremity from the shoulder through the metacarpo-phalangeal joints of the fingers and all joints of the thumb. Cutaneous innervation of the posterior aspect of the superior extremity is also supplied by the posterior cord. The anterior divisions of the three trunks form the lateral and medial cords. The positioning of the fingers in Figure #4 shows how the upper and middle trunks unite to form the lateral cord, while the lower trunk forms the medial cord. Cutaneous innervation to the antero-lateral aspect of the extremity is supplied via the lateral cord, while the medial cord supplies cutaneous innervation to the antero-medial aspect.

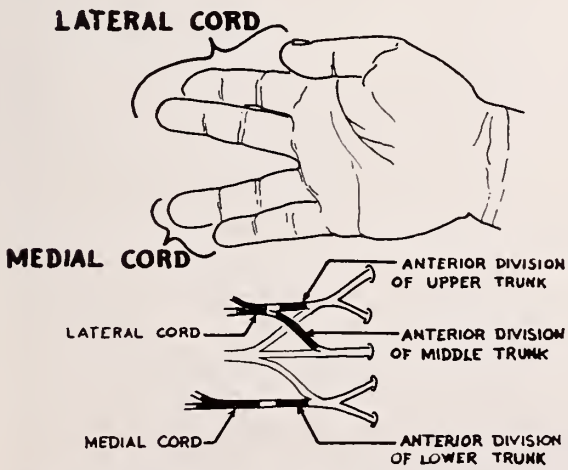

FIG. 4 Positioning of the fingers to illustrate unions of the anterior divisions of the three trunks forming the medial and lateral cords.

The fifth positioning of the fingers shown in Figure #5 illustrates the formation of the major nerves of the brachial plexus from branches of the lateral, medial, and posterior cords. A pencil or any cylindrical object may be clasped by the fingers as shown here to represent the axillary artery. In this way the three-dimensional nature of the brachial plexus and its relationship to the axillary artery may be visualized.

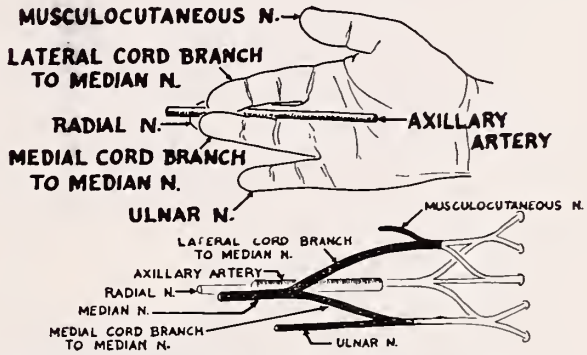

FIG. 5 Positioning of the fingers to clasp a pencil or other cylindrical object, to represent the union of the branches of the medial and lateral cords forming the median nerve and the relationship of the cords to the axillary artery.

One branch of the lateral cord unites with a medial cord branch, thus forming the median nerve, while the other lateral cord branch forms the musculo-cutaneous nerve. The latter innervates muscles which flex the elbow (bear in mind however, that the biceps is also a powerful supinator of the forearm).

The medial cord like the lateral gives off two branches, one contributing to formation of the median nerve, while the other forms the ulnar nerve. In general, the ulnar nerve innervates some of the flexor musculature on the ulnar or medial aspect of the forearm and most of the intrinsic musculature of the hand except for the thumb and the lumbricals of the index and middle fingers. Of the thenar musculature, only the adductor pollicis receives innervation from the ulnar nerve.

A Five-Fingered Mnemonic for the Brachial Plexus—Peck

As noted in Figure #5, the median nerve is formed by coalescence of one of the lateral cord branches with one of the medial cord branches. The median nerve innervates the bulk of the forearm flexor musculature. The bulk of the thenar musculature (except for the adductor pollicis) is innervated by the median nerve, which also innervates the lumbricals of the index and middle fingers.

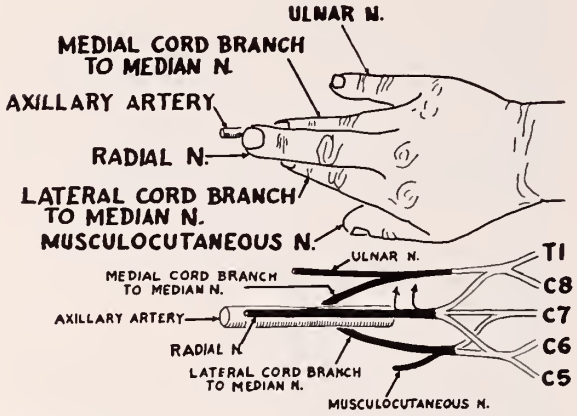

FIG. 6 Posterior view of the positioning shown in Fig. 5 showing the relation of the cords to the axillary artery and the major nerves of the brachial plexus.

In Figure #6 one views the positioning of the fingers given in Figure #5 from the posterior aspect, thus further helping to visualize the three dimensional nature of the brachial plexus. From this posterior view the formation of the posterior cord from the posterior divisions of all three trunks is once again emphasized and its relation to the axillary artery is illustrated.

The major branches of the posterior cord are the thoracodorsal, axillary, and radial nerves. The thoracodorsal nerve innervates the lattissimus dorsi and the axillary nerve innervates the deltoid. The remainder of the extensor musculature of the extremity is innervated by the radial nerve (with the exception of the intrinsic hand musculature responsible for extension of the interphalangeal and distal interphalangeal joints of the index, middle, ring, and little fingers).

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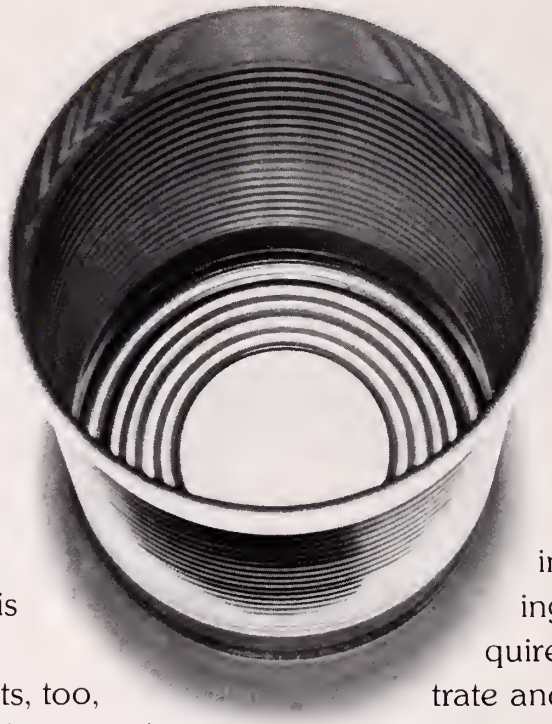

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Ultrasound Evaluation of the Gallbladder

D. B. Short, M.D.; J. M. Schwab, M.D.; J. Cooke, M.A.; J. W. Tyson, M.D.
G. F. Drasin, M.D.; and C. S. Wheeler, M.D.

Louisville, Kentucky

A study showing the role of ultrasound in the patient suspected of having gallbladder disease revealed an overall accuracy rate of 93%. In addition to accuracy, the benefits of this diagnostic procedure include detection of other disease processes and serving as an alternative to radiography and the double dose cholecystogram.

ANATOMICALLY, the gallbladder is a nearly ideal organ for evaluation by ultrasound. It is generally constant in size, configuration, and position. Because of its relatively superficial location behind the lower portion of the right lobe of the liver, problems related to image degradation from depth and overlying bowel gas are minimized. As it is a fluid filled structure, the walls of the gallbladder are distinct.

Clinically, the evaluation of the gallbladder by means of an orally administered contrast agent often leads to problems because of poor visualization following a single dose of the contrast material. A "double dose" evaluation of the gallbladder is a costly study in terms of patient and physician time and in increased radiation exposure.

Materials and Methods

Sixty-seven patients were scanned with a commercially available gray scale ultrasound unit using a 2.25 MHz focused transducer. Fasting patients were scanned in the supine and erect positions during suspended inspiration.

Unlike certain previous studies which considered correlation of the ultrasound evaluations to oral cholecystograms to be adequate evidence of accuracy,[1,2] this project required surgical proof of the ultrasound diagnoses. Operative and/or pathology reports were obtained for 29 patients. Thirty-two patients did not have surgery and six records were unavailable or inconclusive.

From the Department of Radiology, Jewish Hospital, Louisville.
Received at KMA: 9-26-77

Results

Of the 29 patients with surgically proven diagnoses, a positive ultrasound diagnosis of cholelithiasis was made in 19. Seventeen were confirmed at surgery; no stones were present in two.

Five studies were interpreted as showing normal size gallbladders without stones; and in each case the gallbladder was normal at surgery.

In two cases, the gallbladder could not be visualized by ultrasound or double dose cholecystograms. One of these patients had gallstones and chronic fibrosing cholecystitis. The other had widespread hepatocellular carcinoma with extensive adhesions and ascites. At autopsy he was also shown to have chronic cholecystitis, stones, and a mucocele of the gallbladder.

The three remaining patients were diagnosed on ultrasound as having dilatation of the gallbladder and the biliary ductal system, but no stones. These findings were confirmed at surgery in two patients. In addition, the third patient was found to have multiple small stones.

The overall accuracy of ultrasound in the diagnosis of gallbladder disease in this study was 93%. In general, scans positive for cholelithiasis correlated well with positive radiography or nonopacification on double oral dose cholecystograms. However, a normal oral cholecystogram

FIG. 1 Transverse scan of a normal gallbladder (g). The walls are well defined and no internal echoes are present. There is acoustical enhancement posterior to the gallbladder. On this and the following transverse scan "R" indicates the patient's right side.

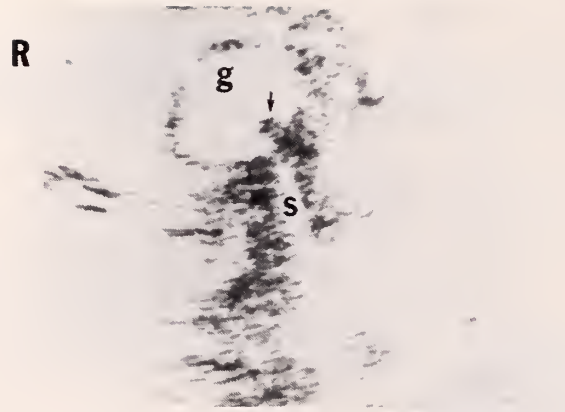

FIG. 2 Transverse scan of the gallbladder (g) showing cholelithiasis (arrow). An echo free band, "acoustical shadow" (s), is seen posterior to the gallstones.

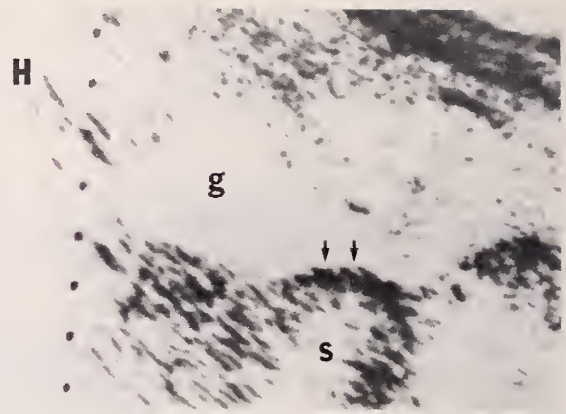

FIG. 3 Longitudinal scan of the gallbladder (g) showing cholelithiasis (double arrow) and a posterior "acoustical shadow" (s). On this and the following longitudinal scan "H" indicates the head of the patient.

was reported for one patient whose ultrasound scan and subsequent cholecystectomy revealed multiple small stones.

One patient who had a dilated gallbladder and biliary ducts demonstrated by ultrasound also had small stones at surgery. The small stones were not detected by ultrasound, but the dilated biliary system was reported. False negative results on ultrasound, in the detection of gallstones, are usually related to an inability to detect very small stones.[3]

Two false positive diagnoses of cholelithiasis were made by ultrasound. In one case, the ultrasound examination demonstrated intraluminal filling defects compatible with gallstones. The gallbladder was described on operative and pathology reports as edematous and showing "subsiding acute cholecystitis", but no stones were present. In the other case, the ultrasound diagnosis was small stones and biliary sludge accumulation, but the laparotomy was negative for gallbladder disease. (Table 1)

Table 1

ULTRASOUND DIAGNOSIS		SURGICAL DIAGNOSIS	
		Confirmed	Not Confirmed
Stones	19	17 (89%)	2 (11%)
Non Visualized (Presumed abnormal)	2	2	
Obstruction	3	3	
Normal	5	5	
	29 (100%)	27 (93%)	2 (7%)

Discussion

Ultrasound has been used to detect gallstones for over two decades, but only in the last few years has diagnostic accuracy reached an acceptable level. [1,4,7] Recent technical improvements in ultrasonic scanners as well as awareness of the multiple presentations of gallstones made ultrasonic cholecystography a valuable procedure, with an accuracy comparable to oral cholecystography. The more recent reports in the literature report an accuracy of from 91-96%.[1,3,6] This rapid noninvasive procedure is an ideal alternative to radiography for patients where jaundice or acute illness precludes the use of the oral cholecystogram.[8] In many instances, the ultrasound examination of the gallbladder provides valuable supplemental information as to the presence of other disease processes.[2,3,9,11] For example, two patients in our study were shown to have dilatation of the gallbladder and biliary ductal system. In one patient this was secondary to a carcinoma of the pancreas, and in the second patient an adenocarcinoma encircling the common and cystic ducts was found at surgery.

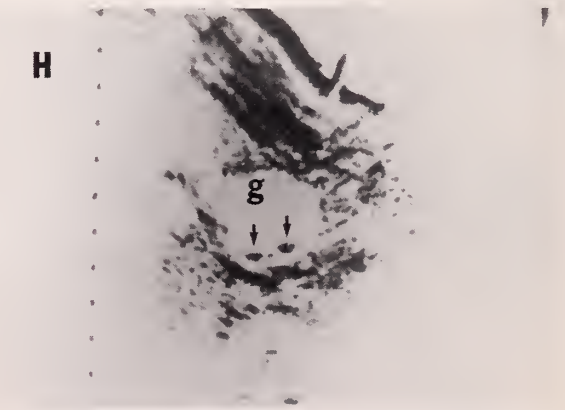

FIG. 4 Longitudinal scan of the gallbladder (g) showing cholelithiasis (double arrow) without acoustical shadowing.

Ultrasound cholecystography is also an attractive alternative to the double dose cholecystogram, particularly when dealing with outpatients. Patients with a non-visualized gallbladder following a single dose of contrast material could be examined by ultrasound on the same day and not have to return for a second dose study thus eliminating additional radiation exposure.

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EDITORIAL

Please Seat Barry To My Left

BECAUSE of my political leaning, friends and adversaries have placed me just to the right of Barry Goldwater. In today's climate, perhaps this is not a bad location.

I recently read where the Department of Health, Education and Welfare had considered to stop funding PSRO's, and long have I been an opponent of KPRO. At hospital staff meetings I spoke out against being a participating hospital—and lost. Later, I was asked to chair the committee on Utilization Review and KPRO —I accepted. So now the fox is in charge of the hen house. I gird my loins and await the gathering storm. Yet, I am not alone. I sense friendly forces on the horizon.

From the press clippings and TV documentaries I have seen there has been a slow and gentle erosion of the liberal swing of the 1960's. There has been some disenchantment with and even arrest of many of the "Give Away" programs that have been counterproductive or ineffectual. Welfare cheaters and Medicare and Medicaid fraud are being discovered by computer cross indices. The great (?) Social Security Program that promised so much in the 1930's now promises to become the albatross of the 1980's. The U.S. Postal Service has become so mired down in the bureaucratic pork barrel that now its most recent salvation has been to print a bigger number on a smaller stamp.

The recent three-hour NBC documentary on Life, Death, and Dollars, was not too tough on us. When American Medicine can come up on the plus side with one of the great news media, our position must be improving.

It is we, the physicians, who can best maintain this gradual shift to the right. We are our own best ambassadors of good will. The public may criticize doctors as a whole, but as individuals we still rank first in trust and confidence. Let us remain worthy of this station.

MLM

Simple drops of water help make COLACE® the most widely used stool softener.

COLACE®
dioctyl sodium sulfosuccinate

COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- or long-term therapy. COLACE—the simple water way to ease constipation from infancy to old age. Capsules, syrup or liquid.

Mead Johnson PHARMACEUTICAL DIVISION

Evansville, Indiana 47721 U.S.A.

COMPATIBILITY

Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.
Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.
Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson
PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson
PHARMACEUTICAL DIVISION

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ASSOCIATIONAL NEWS

Interprofessional Code Outlines Physician, Attorney Relations

During the past several months, a number of complaints have been received by the Physician Attorney Liaison Committee concerning disagreements between physicians and attorneys regarding physicians' fees for medical reports, depositions, and court appearances.

Members of the Kentucky Medical Association and the Kentucky Bar Association are urged to discuss fees for such services prior to these services being rendered. Many disagreements between physicians and attorneys may be avoided if fees charged for providing medical reports, depositions and court appearances are discussed in advance.

The Interprofessional Code was drawn up by members of the Physician-Attorney Liaison Committee, composed of three members of KMA and three members of KBA, and was approved by the governing boards of the two associations to aid in the attainment of the best in interprofessional conduct and relations. The following quote from the Interprofessional Code regarding *Compensation for Medical Reports, Depositions and Court Appearances* is reprinted for information:

It is impractical to establish precise rules governing a physician's fees for medical reports, depositions, and court appearances. It is important, however, that fees be reasonable, and it is suggested that they be discussed in advance by the physician and the attorney. In this way, the major cause of misunderstanding and dissatisfaction will be eliminated. UNDER NO CIRCUMSTANCES MAY A PHYSICIAN CHARGE A FEE FOR AN EXAMINATION OR FOR TESTIFYING WHICH IS CONTINGENT UPON THE OUTCOME OF THE LAWSUIT.

As a matter of policy, an attorney should not request a physician to testify on deposition or in court, nor should he subpoena him without making arrangements for reasonable compensation. This is not required by law, but is suggested as a matter of fairness and cooperation between the professions. A physician should be compensated for the time spent away from his professional practice, regardless of whether he is used as a witness.

Update on KMA Insurance Company

The officers and staff of KMA have spent many hours recently in continuing their plans for the establishment of a professional liability insurance company for Kentucky physicians. As previously reported, the company would sell both primary and excess coverage and would be a Kentucky physician-owned and operated company.

In the initial stages, KMA would form an insurance agency and would sell primary and excess coverage offered by the Physicians Insurance Company of Ohio (PICO), which is a physician-owned Company in the State of Ohio. As soon as KMA receives sufficient capital to charter our own company, PICO will withdraw from the market and KMA's own insurance policies would replace those of PICO.

More timely information will be provided to Kentucky physicians through the *Communicator* and/or direct mailings.

Board of Trustees' Digest For December Meeting

The KMA Board of Trustees held its second meeting of the Associational year on Wednesday, December 14, and Thursday, December 15.

The Headquarters Office Report was made by the Executive Vice-President, who noted substantial increases in membership and finances.

In his report on the recent AMA Interim Meeting in Chicago, Doctor David Stevens announced that the AMA House of Delegates approved direct specialty representation whereby approved specialty societies would be able to elect their own delegates to AMA. He stressed that the primary goal of the KMA delegation in 1978 was the election of Hoyt Gardner, M.D., as President-Elect of AMA.

Neville Caudill, M.D., President of the Kentucky Peer Review Organization, reported that KPRO expected to be implementing review in all hospitals certified by Medicare and Medicaid by the end of February, 1978.

A Kentucky Pharmaceutical Association resolution dealing with the use of a rubber stamp on prescriptions to identify a physician, his DEA or license number, was endorsed by the Board.

The major item of discussion concerned liability insurance. The Board reviewed the House mandate calling for establishment of a KMA insurance company, the studies made of other states on this issue, the recent liability insurance survey conducted by KMA, and the discussions held with the Physicians' Insurance Company of Ohio (PICO). After lengthy discussion (a tape of which is on file at the Headquarters Office), the Board voted to establish a Kentucky insurance agency in affiliation with PICO to offer primary and excess coverage on an occurrence basis and to oppose any legislation to form a Patients' Compensation Fund.

A number of KMA committees reported at the Board meeting:

The **State Legislative Activities Committee** has formed a position on all medically-related bills that were prefiled in the Legislature. The Board gave authorization

to the Quick Action Committee to make necessary decisions on any impending state and national legislative matters. In related action, the Board approved a request of the **National Legislative Activities Committee** to hold the Washington Dinner in 1978.

Using information reported by the **Cancer Committee,** the Board endorsed the concept of a statewide tumor registry and recommended it be operated and located at the University of Kentucky. The **Council on Health Care Costs** issued a report of its activities since its formation.

Due to a similar seminar being held by the University of Kentucky, the **Committee on School Health, Physical Education and Medical Aspects of Sports** has decided not to hold its annual sports seminar in 1978. In other action, the Board urged this Committee to survey state high schools on team physician use.

The **Ad Hoc Committee on Primary Care** submitted guidelines for the Board's information for primary care physician extenders and the **Committee on Community and Rural Health** announced plans to co-sponsor with the University of Louisville a seminar on "The Medical Management and Special Problems in Treatment of Alcoholism," on May 24-25, 1978.

Mr. Avil McKinney, Executive Vice-President of Kentucky Blue Cross and Blue Shield, gave a thorough presentation on premium rates for the KMA Program for physicians and their employees. He also commented extensively on the rate review legislation to be presented to the 1978 Legislature.

Secretary for Human Resources, Peter D. Conn, met with the Board and held a lengthy discussion on several informational items: (1) He plans to extend the radiation operators' certification deadline for six months. (2) He supports KMA's feelings concerning physicians serving on local boards of health. (3) He announced his intention to seek legislation to create an office of the Surgeon General and outlined the role of this position which would be filled by a physician. (4) He asked for KMA assistance in revising the Health Planning Law.

Annual Resident's Workshop Set For April 25-26

The Kentucky Medical Association will again sponsor the resident workshop entitled, "Establishing Yourself in Medical Practice," which will be held on April 25-26, 1978, at the Ramada Inn-Bluegrass Convention Center, Louisville.

The program consists of two days of intensified training for senior residents who are preparing to enter private practice and will deal with such subjects as personnel problems, patient flow techniques, physical aspects of the medical office, clinical and financial paperwork, practice location, and legal problems. The workshop has been greatly received in the past and those interested should register as soon as possible as enrollment is limited.

For additional information on this workshop, please contact the KMA Headquarters Office.

Trustees' Report

SECOND TRUSTEE DISTRICT
R. J. Phillips, M.D., Owensboro

Response to the recent KMA insurance survey was not sufficient to establish an umbrella fund that would receive State Insurance Commission approval. Discussions by physicians in the Second District indicate that many are adequately served by existing policies. Some doctors believe that high level of insurance coverage is the problem, rather than the solution. There is concern about the philosophy of "Patients Compensation Fund" that is imposed by insurance settlements when malpractice has not been shown to exist. A practical solution for those physicians who need more coverage seems most likely through the plan for an agency to provide umbrella policies from the Physician's Insurance Company of Ohio. Through such an agency, a Kentucky company may finally be established.

While sufficient insurance coverage may become available to all physicians, the need for tort reform is not decreased. We—and our elected representatives to the Legislature—should continue to evaluate our rights to contingency fees, punitive damages, statute of limitations, and to file suit without basis.

FOURTH TRUSTEE DISTRICT
Charles B. Spalding, M.D., Bardstown

There have been no great changes in the District since my last report. (May, 1977) The Elizabethtown hospital is in the process of completing a 40-bed expansion and will offer new services, including diagnostic ultrasound. Nephrology will also be offered to the community. Campbellsville is adding 30 beds to its hospital and now has the services of another surgeon, obstetrician, and soon will have the services of an ENT specialist.

After discussing problems in the District, the main concerns are x-ray and laboratory regulations and regional planning that might cause closure of services available in some of the lesser populated counties. The yearly District meeting will be tentatively held in Elizabethtown in April. A future mailing will be more specific.

Don't Forget . . .

1978 KMA Annual Meeting

September 26-28

Hyatt Regency/Lexington Center

Kefzol® I.M./I.V.
cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm., and 10 Gm. of cefazolin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

Members in the news

NEW MEMBERS

BOONE

Charles Caldwell, M.D., Florence
David Shearer, M.D., Florence

BOYD

John R. Potter, M.D., Ashland

BOYLE

Alvin R. Harrison, M.D., Danville
Eldridge M. Montgomery, Jr., M.D., Danville

CAMPBELL-KENTON

Elliott M. Friedeman, M.D., Bellevue

DAVIESS

Jack C. Blackstone, Jr., M.D., Owensboro
Bryan P. Warren, Jr., M.D., Owensboro

FAYETTE

William T. Mattingly, M.D., Lexington

FLEMING

William A. Rye, M.D., Flemingsburg

HOPKINS

Richard P. Nero, M.D., Madisonville
Manojkumar Shah, M.D., Madisonville

JEFFERSON

William E. Ackerman, III, M.D., Louisville
Donald E. Fry, M.D., Louisville
Daniel C. Gralnick, M.D., Louisville
Ronald M. Kimberlin, M.D., Louisville
Charles F. Morris, Jr., M.D., Louisville
Jairo Ramirez-Lozano, M.D., Louisville
Marand Sridharan, M.D., Louisville

LAUREL

Anil Prakash, M.D., London

MADISON

Stuart Tobin, M.D., Richmond

McCRACKEN

Jack D. Diles, M.D., Paducah
James M. Hawkins, M.D., Paducah
Frank J. Kolb, III, M.D., Paducah
Robert C. Ripley, M.D., Paducah

MERCER

William L. Riker, M.D., Harrodsburg

PENNYRILE

Willard L. Keith, M.D., Greenville

SCOTT

David Marwil, M.D., Georgetown
Ben Santa-Teresa, M.D., Georgetown

UNION

Marle Malubay, M.D., Sturgis

IN MEMORIAM

FRANKLIN G. HOFFMAN, M.D.
Louisville
1913-1977

Franklin G. Hoffman, M.D., 64, died on December 18, 1977, in Louisville. A 1942 graduate of the University of Cincinnati College of Medicine, Doctor Hoffman was Associate Professor of Medicine at the University of Louisville. A cardiologist, he was a Fellow of the American College of Physicians and the American College of Cardiology. He was a member of the Jefferson County Medical Society and the Kentucky Medical Association.

WILLIAM J. CAREY, M.D.
Lexington
1931-1978

William J. Carey, M.D., died on January 9, 1978, at the age of 46. A member of the faculty of the Department of Anesthesiology at the University of Kentucky, Doctor Carey was a 1962 graduate of the University of Louisville School of Medicine. He was an active member of the Kentucky Medical Association, having been a current member of the Emergency Medical Care Committee. He also belonged to the Fayette County Medical Society and the American Medical Association.

Headquarters Activity

JANUARY

3	1978 Kentucky General Assembly Convenes, Frankfort
4	Interspecialty Council on Insurance, Louisville
14-15	KMA Board of Trustees, Louisville
3-7	Professional Convention Management Association, San Antonio
9	*Journal* Editors, Louisville
12	Membership and Placement Services Committee, Louisville

FEBRUARY

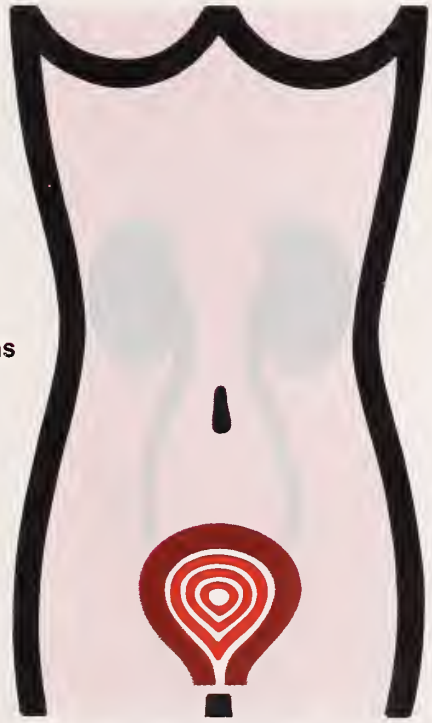
2-5	AMA Conference on Education, Chicago
6	*Journal* Editors' Meeting, Louisville
8	Cancer Committee, Louisville
9	Technical Advisory Committee on Physician Services, Louisville
15	Judicial Council, Louisville
23	Membership and Placement Services Committee, Louisville

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens



□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

*Nonobstructed; due to susceptible organisms

□ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—

Social Security Bill Is Signed Gives Pensions to Aged, Jol

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws-He the Measure 'Cornerstone' of His Economic Progr

WASHINGTON, Aug. The Social Security Bill, a broad program of unem insurance and old age and counted upon to ben 20,000,000 persons, becan day when it was signed dent Roosevelt in the pr those chiefly responsible ting it through Co

Mr. Roosevelt cal "the cornerstone which is being me s comple

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0, and sent

TRUMAN CLOSES ITED NATIONS CONFEREN WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

SAN FRANCISCO, June 26, 1945

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the eight United States delegates to

SIGN

the Dra Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that he foresees no need for

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

Application for Scientific Exhibits

1978 Annual Meeting — Kentucky Medical Association

Hyatt Regency / Lexington Center — **Lexington, Kentucky** — **September 26, 27, 28**

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before July 1, 1978.

ACCREDITATION

KAFP allows one credit hour for each hour of participation and presentation of scientific exhibits up to 15 hours. AMA allows up to 10 hours for AMA Category 4 credit.

1. Title of exhibit _____
2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____
3. Institution if other than exhibitor _____
4. Amount of backwall footage required _____
   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required.)
   SHELF DESIRED? _____ (Shelf is 2′ deep × width of backwall footage)
5. Will summary printed matter be available or obtainable for the interested physician? _____
6. Indicate sources of assistance provided to you in connection with this exhibit _____

   _____
7. Has this exhibit been displayed before? If so, when & where? _____

   _____
8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation, and (b) the method, eg., equipment to be used.

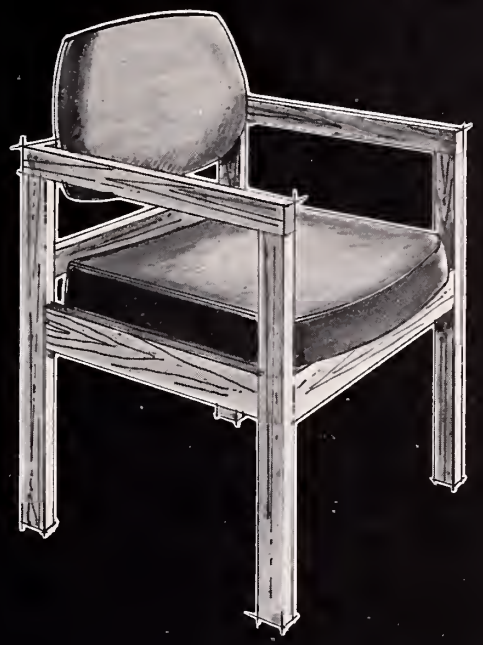
Date _____ _____

Signature of Applicant

Fill Out and Mail to:

RICHARD A. KIELAR, M.D., Chairman
Scientific Exhibits Committee
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

- **KMA provides, without cost to the exhibitor, simple shelves, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc., may be furnished by the exhibitor or may be rented, if desired, by applying directly to the Joseph T. Griffin Company, 704 West Main Street, Louisville, Kentucky 40202**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise should not be used during the general sessions and, at other times, should be controlled by head or earphones or a muffling device.**



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According to recent surveys by two leading pharmaceutical journals, Purepac is the number one generic most preferred by pharmacists in the United States. Yet, it's quite possible you've never even heard of us. Simply because Purepac has no detail men.

That's good news and bad news.

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Bad news because we're unable to personally tell you about Purepac's quality control and new drug applications. Or that our bioequivalence is every bit as good as the more expensive national brands.

Matter of fact, Purepac generics are equivalent to all brand names in every respect, except for one... PUREPAC COSTS LESS.

So while it's true we could use the extra recognition a staff of detail men could give us, perhaps the reverse is also true. That we can get a lot more recognition by passing the savings on to your patients in every Purepac prescription.

See the Purepac listing in the white pages of the 1978 PDR.

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Pages 5-13 were missing, [illegible]

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
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Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.

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For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

LIBRIUM® CIV

chlordiazepoxide HCl/Roche

THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

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Volume 76 • March 1978

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MESSAGE FROM THE PRESIDENT

The Public Concern

We physicians have enjoyed the privilege, for most of our medical careers, of practicing in a free and unoppressed atmosphere. During this time the need for certain changes in the delivery of health care and health costs has become increasingly apparent. We are rightly concerned about the complexity of these problems, stemming from our society's desire for a better health care system. Thoughtful citizens are interested in helping find workable solutions and it is with this responsible sector that we must achieve greater understanding and cooperation.

Physicians are now dealing with many divergent groups that represent different viewpoints on health care; many of these are self-serving. Unfortunately, and saddest of all, the physicians and their medical organizations are regarded by some as among the most intransigent of adversaries, more interested in themselves than in the delivery of health care. Not well publicized is the fact that the Kentucky Medical Association and the county medical societies continue to devote many volunteer hours for the public good. In one particular instance, with which I am familiar, during a 12-month period a total of 2,671 hours were contributed by physicians to enable a county medical society to function. Of these hours over 63% were devoted to the community and its protection. This is keeping the public trust!

We are aware that health care issues in the form of Senate and House Bills emanating from Frankfort need to be examined and discussed. Consequently, we must have active physician participation to help assess and initiate progressive changes which we can support and to identify those irresponsible proposals that would be detrimental to patient care. We should keep our patients informed since they are so intimately affected by health care decisions. We must keep ourselves acquainted with the depth and breadth of medical care and in so doing achieve a greater sensitivity to the needs of others. The solutions will be attained only when there is full understanding by the public of the many factors involved.

Physicians can and should be the major influence in promoting understanding of medical decisions and their consequences. We need health planning and its implementation should come from physicians working with other providers and citizens rather than through Federal Government regulations. Our sincere efforts to understand the public's point of view, tempered by what we know is possible, will benefit society as a whole, and maintain the stature of the medical profession.

Robert S. Howell, M.D.
KMA Vice President

This is the second in a series of articles written at the request of KMA President John P. Stewart, M.D.

POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

MARCH

22 "The Mitral Valve Complex and its Disorders**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29 "Burn Treatment**," Louisville Area CME Consortium, Health Sciences Center, Louisville

29-30 Twenty-fourth Annual Symposium on Cardiovascular Diseases, University of Louisville Health Sciences Center, Louisville

APRIL

6 Twenty-third Annual Spring Clinical Conference, Lexington Clinic, Lexington

8 Cancer Update in the Park, "Colorectal Cancer," Kentucky Division, ACS, Barren River Lake Resort Park

10-11 Seventh Annual Medical Aspects of Sports Symposium: Prevention of Sports-Related Injury, Hyatt Regency Hotel, Lexington

12 "Interplay of X-ray and Endoscopy on Gastroenterology**," Louisville Area CME Consortium, St. Joseph Infirmary, Louisville

14-15 "Diabetes Control: Why and How*," University of Kentucky, Hyatt Regency, Lexington

18-25 "Controversies in Care: Obstetrics and Gynecology*," University of Kentucky College of Medicine, 30 hrs. credit, (Package Fee: $850), Maui, Hawaii

20-22 "High Risk Pregnancy**," University of Louisville, Executive West, Louisville

22 Cancer Update in the Park, "Gynecological Cancer," Kentucky Division, ACS, Kenlake State Resort Park

24-27 Postgraduate Course in Surgical Anatomy**, Health Sciences Center, Louisville

25-26 Establishing Yourself in Medical Practice Workshop, Ramada Inn-Bluegrass Convention Center, Louisville

26-27 Negotiations Seminar, co-sponsored by KMA and AMA, Louisville

28-May 1 Fourth Annual Postgraduate Course in Surgery, University of Louisville, Galt House, Louisville

**For further information, contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, University of Kentucky College of Medicine, Lexington 40506*
***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

MAY

4-5 "Medical and Behavioral Problems in Older Persons*," University of Kentucky College of Medicine, 12 hrs. credit, (Fee: $80), Hyatt Regency Lexington

17-19 "Surgical Diseases in Children: Radiologic Evaluation and Operative Correlation*," University of Kentucky College of Medicine, 15 hrs. credit, (Fee: $180, physicians; $90, residents), Hyatt Regency, Lexington

19-20 Spring meeting, Kentucky Surgical Society, Lake Cumberland State Park

20 Cancer Update in the Parks, "Childhood Cancer," Kentucky Division, ACS, General Butler State Resort Park

24-25 "Medical Management and Special Problems in the Treatment of Alcoholism," University of Louisville School of Medicine, Executive Inn, Louisville

24 "Diagnosis and Management of Arrythmias Associated with Myocardial Infarction**," Louisville Area CME Consortium, Health Sciences Center, Louisville

27-28 "Advanced Cardiac Life Support, Instructors Course**," University of Louisville School of Medicine, 18 hrs. credit, (Fee: $125), Health Sciences Center, Louisville

30 "Dizziness**," Louisville Area CME Consortium, Health Sciences Center, Louisville

IN SURROUNDING STATES

APRIL

1 "Aging," University of Cincinnati College of Medicine and CONMED, 5½ hrs. credit, (Fee: $30), Cincinnati

4-5 March of Dimes Symposium, "Perinatal Medicine, Present and Future Advances," Holiday Inn O'Hare, Kennedy Hotel, Chicago. Contact: March of Dimes, 53 W. Jackson Blvd., Chicago 60604.

5-7 31st AMA National Conference on Rural Health, Regency Hotel, Denver

6-7 Annual Meeting, Region II, American Association for Respiratory Therapy, Cleveland Plaza Hotel, Cleveland. Contact: A.A.R.T., 1720 Regal Row, Dallas, Texas 75235

20 Seminar on Gynecologic Surgery and Oncology, University of Cincinnati Medical Center and CONMED, 5¾ hrs. credit, (Fee: $65), Cincinnati

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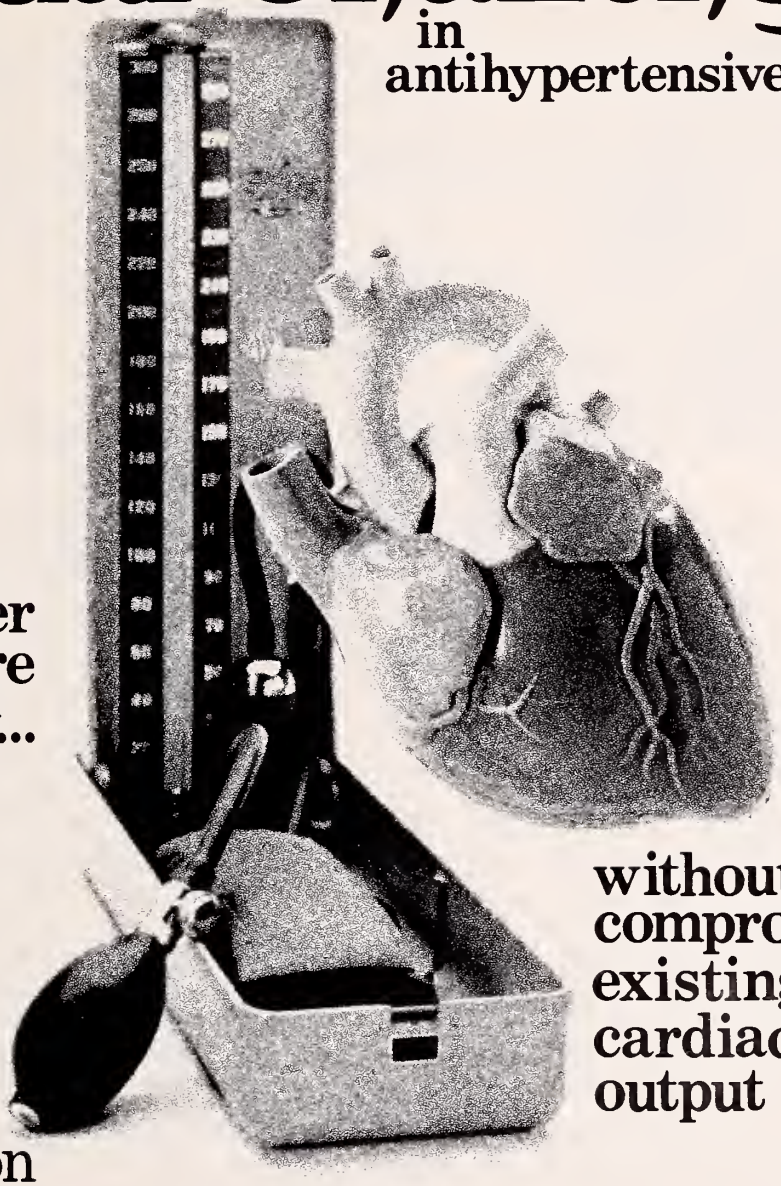

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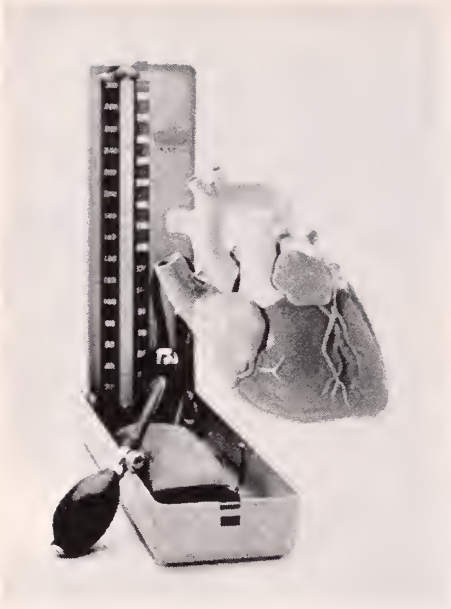

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With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

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Wilms' Tumor—A Review of 49 Consecutive Cases Over a 23-Year Period

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Louisville, Kentucky

Increased survival in childhood Wilms' tumor is noted over a 23-year period with the advent of modern combined therapy. Non-visualization on initial IVP films was frequent and did not carry a grim prognosis.

THE survival of children with Wilms' tumor has steadily improved over the past two decades with the carefully planned use of combined therapy including surgery, irradiation, and chemotherapy. Direction of therapeutic programs has wisely come from large tumor registries such as the Children's Cancer Study Group (CCSG) and the National Wilms' Tumor Study (NWTS). Modern treatment of children with Wilms' tumor combines surgery with postoperative radiotherapy and chemotherapy utilizing Actinomycin D and Vincristine in combination.[1-4] Recent evidence from NWTS suggests that radiotherapy may not greatly affect survival in children under two years of age with clinical Stage 1 Wilms' tumor.[1]

The experience with Wilms' tumor at the Louisville Children's Hospital from 1953 to 1976 is presented. Prior to 1968, Wilms' tumor was treated at this institution by a variety of individually conceived therapeutic regimens. Since 1968, however, therapy has been determined by the protocols of the Children's Cancer Study Group and the National Wilms' Tumor Study.

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Received at KMA: 9-15-77.

Materials and Methods

Forty-nine patients with Wilms' tumor were treated at the Children's Hospital of Louisville, 19 prior to 1968 and 30 from 1968 to 1976. Forty-seven of these patients were treated exclusively at the Children's Hospital and two patients were referred to our institution immediately following surgery for appropriate radiotherapy, chemotherapy, and continued follow-up in the tumor clinic. The records of all patients were reviewed in detail including operative notes, pathology records, treatment, and follow-up records. The data was compiled for completeness using modifications of the National Wilms' Tumor Study registration protocol forms. Clinical stage was assigned after thorough study of each patient's record utilizing standard staging criteria[1]:

> The patient's group is decided by the surgeon in the operating room, and is confirmed by the pathologist. If the histological diagnosis and grouping will take more than 48 hours, the surgical grouping stands, the patient is registered, and started on treatment.
>
> **Stage I**—Tumor limited to kidney and completely resected.
>
> The surface of the renal capsule is intact. The tumor was not ruptured before or during removal. There is no residual tumor apparent beyond the margins of resection.
>
> **Stage II**—Tumor extends beyond the kidney but is completely resected.

There is local extension of the tumor; i.e., penetration beyond the pseudocapsule into the peri-renal soft tissues, or peri-aortic lymph node involvement. The renal vessels outside the kidney substance are infiltrated or contain tumor thrombus. There is no residual tumor apparent beyond the margins of resection.

Stage III—Residual nonhematogenous tumor confined to abdomen.

Any one or more of the following occur: 1) The tumor has been biopsied or ruptured before or during surgery; 2) there are implants on peritoneal surfaces; 3) there are involved lymph nodes beyond the abdominal peri-aortic chains; 4) the tumor is not completely resectable because of local infiltration into vital structures.

Stage IV—Hematogenous metastases.

Deposits beyond Group III; e.g., lung, liver, bone, and brain.

Stage V—Bilateral renal involvement either initially or subsequently.

Table 1
AGE AT DIAGNOSIS

0 - 6 Months	4
6 - 12 Months	3
12 - 24 Months	7
2 - 5 Years	18
5 - 10 Years	15
> 10 Years	2
	49

Clinical Features

The age at the time of diagnosis is tabulated in Table 1. The majority of the children were under 10 years of age with a peak incidence between the ages of two and five years. There were 29 males and 20 females with 40 caucasians and 9 blacks. The tumor was on the right side in 24 cases (49%), the left side in 22 cases (45%), and bilateral in 3 cases (6%).[5] The distribution by stage was: Stage I, 21 patients; Stage II, 16 patients; Stage III, 3 patients; Stage IV, 6 patients; and Stage V, 3 patients.

Presenting symptoms and signs are listed in Table 2. The finding of an abdominal mass was the most common presenting sign and the most frequent reason for a visit to a physician. In a significant number of children, hematuria was the reason for first seeking medical attention, the mass being discovered on initial physical examination. In three patients, the reason for referral was totally unrelated to the Wilms' tumor, the mass being discovered incidentally on physical examination. One of these patients was admitted for observation following abdominal trauma and the mass was discovered at that time. Pain, hypertension, and GI symptoms were quite infrequent initial findings in this series.

Table 2
PRESENTING SYMPTOMS

	# of Patients	% of Patients
Mass	47	96%
Hematuria	14	28%
Pain	1	2%
Hypertension	1	2%
Other	5	10%

Tumor size at the time of resection was less than 5 cm in two patients; between 5-10 cm in 12 patients, and greater than 10 cm in 35 patients.

Diagnostic Studies

Admission laboratory studies including routine hemogram, electrolytes, glucose, and urinalysis were obtained in all cases and were of little diagnostic aid. Hematuria was gross in most cases.

Chest x-rays were obtained in all patients and demonstrated pulmonary metastases in four of six Stage IV patients. Plain abdominal x-rays showed evidence of a flank mass in 36 of 49 cases. There was no radiographic evidence of abdominal calcification in any of our patients.

Intravenous urography was performed in all patients. In 40 patients the presence of a renal tumor was readily apparent. In the remaining nine patients (20%), the involved kidney did not visualize radiographically, even with delayed filming. This nonvisualization could be explained by either gross or microscopic vascular invasion or gross invasion of the renal pelvis in five patients. In one other, the tumor angulated the ureteropelvic junction, resulting in complete obstruction. Almost total bilateral replacement of renal parenchyma accounted for non-visualization in one child with obvious advanced disease who died shortly after surgery. There was no suitable explanation for non-visualization in two patients. One of these patients developed pulmonary metastasis two years after primary resection, chemotherapy, and radiotherapy. These

lung lesions were further treated by surgical excision, chemotherapy and radiotherapy. The other child died during surgery from blood loss. Survival data of this group with non-visualization will be discussed separately below.

Arteriography and inferior venacavography were obtained in too few patients to evaluate their diagnostic efficacy. The authors' present approach is to include inferior venacavography in the preoperative evaluation of most patients with Wilms' tumor. Information regarding involvement of the renal vein and the inferior vena cava may affect the operative approach to tumor resection.[6,7]

Treatment

All patients in this series underwent surgical removal of their tumor. Prior to 1968, children at this institution with Wilms' tumor were not treated according to any standardized protocol but rather according to individual programs conceived by their own physicians. Use of chemotherapy and radiotherapy was not standard and dosage schedules for these modalities varied considerably. In 1968, a tumor clinic was established at the Louisville Children's Hospital and all treatment and follow-up of children with cancer has become centralized. Since that time, Wilms' tumor patients have been treated with radiotherapy and chemotherapy in addition to surgical removal of their tumors according to NWTS/CCSG protocols. Briefly, this includes for all stages Actinomycin D intravenously beginning the day of or the first day after surgery in a dosage of 15 μg/kg/day for five days. This is repeated again at six weeks and thereafter at three-month intervals up to 15 months. In 1972, Vincristine, at a dosage of 1.5 mg/m^2 intravenously per week beginning on the seventh postoperative day and continuing for seven weeks, was added to the regimen. This is then further administered at three-month intervals to 15 months. Radiotherapy is delivered also according to the NWTS Protocol schedule in doses of 1800 to 4000 rads to the tumor bed depending upon the age and size of the patient and is begun soon after surgery.[1] In addition, for Stages III and IV, increased sized abdominal ports are used as well as radiotherapy to distant metastatic disease.

Two patients with pulmonary metastases have undergone operative resection of these lesions in addition to the above-mentioned therapies. One of these children eventually died of widespread metastatic disease; the other one is now alive and free of tumor six years after resection.

Close observation of hematologic parameters, skin hygiene, and general nutrition was maintained either on an inpatient basis or by regular visits to the tumor clinic. Follow-up on all patients to date is complete.

Results

Thirty-three of the 49 patients (67%) are presently alive and 32 of these are free of disease. One child recently operated upon with extensive local non-resectable disease as well as metastatic disease to the liver, lungs, and spine is currently undergoing combined therapy. Six of the 49 patients are currently less than two years post-tumor resection, one Stage I, three Stage II, one Stage IV, and one Stage V, and will therefore be excluded from further discussion of survival statistics. We have further divided the survival data in Groups A and B for patients treated prior to and after 1968 when a major change in therapeutic programs occurred. The corrected series of 43 patients with 27 survivors is further segregated by Stage and treatment in Table 3. There is obvious correlation of survival with stage of disease at the time of original presentation in both groups. Age, tumor size, race, and site of original tumor did not correlate with survival. Though

Table 3
SURVIVAL IN 43 PATIENTS WITH WILMS' TUMOR

	Group A pre-1968		Group B post-1968		Total	
Stage	#	%	#	%	#	%
I	8/11	82%	9/9	100%	17/20	85%
II	3/5	60%	6/8	75%	9/13	69%
III	0/1	0%	0/2	0%	0/3	0%
IV	0/1	0%	1/4	25%	1/5	20%
V	0/1	0%	0/1	0%	0/2	0%
Totals	11/19	58%	16/24	67%	27/43	63%

Table 4
IVP VISUALIZATION

	BILATERAL VISUALIZATION			NON-VISUALIZATION		
Stage	Alive	Dead	% Survival	Alive	Dead	% Survival
I	17	2	85%	1		100%
II	6	3	66%	6	1	86%
III		3	0%			
IV	2	4	33%			
V	1	1	50%		1	0%
	26	14	65%	7	2	78%
	Total = 40			Total = 9		
	% of Cases = 80%			% of Cases = 20%		

the numbers are small there are some trends worth noting.

There have been no deaths in patients with Stage I disease since 1968. Three Stage I deaths prior to that time all occurred from local recurrence of disease. In all three patients, the chemotherapy and radiotherapy treatment programs used would be considered inadequate by modern standards. Of the four deaths in patients with Stage II disease, one patient in Group A died on the operating table from a technical error and the other three in Groups A and B occurred as a result of recurrent disease. There were no survivors from Stage III disease. The only survivor with Stage IV disease was a youngster with isolated pulmonary metastases treated with chemotherapy and radiotherapy alone who is alive and free of disease six years after original resection. One other child with recurrent pulmonary metastases treated by multiple bilateral pulmonary resections eventually died of overwhelming metastatic disease. All other deaths in Stage IV patients were from widespread metastatic disease which was apparent at the time of initial presentation. The one Group A Stage V death occurred in the immediate postoperative period as a result of technical complications. This was in a youngster in which both kidneys were essentially totally replaced with tumor. The Group B Stage V death was from recurrent disease.

The survival of patients with non-visualization of the involved kidney on initial urogram is tabulated by stage in Table 4. The only two deaths in this group were the two children who died in the immediate perioperative period, a Stage II patient and a Stage V patient, already discussed. Of the survivors with non-visualization (78%), five had gross invasion of the renal vein or pelvis and all are free of disease, a minimum of five years postresection. In the remaining three, one child had extrinsic uretero-pelvic junction obstruction by angulation from the tumor, one had microvascular invasion and one had no explanation for non-visualization. The latter child developed pulmonary metastases two years following initial resection which were treated by surgical resection. This child is now alive and tumor-free, six years after pulmonary resection.

Discussion

Improved overall survival in Wilms' tumor over the past two decades has largely been due to improved, carefully planned treatment programs including surgery, chemotherapy, and radiotherapy.[4,8,9] Large cooperative studies have now collected significant data to support the current approach to Wilms' tumor utilizing postoperative combination treatment with Actinomycin D and Vincristine and radiotherapy.[1-4] Current studies by the National Wilms' Tumor Study group are underway to evaluate the necessary duration of treatment for different stages. Further, recent studies suggest that postoperative radiotherapy may not influence survival in Stage I patients under the age of two years.[1] We have utilized the NWRS/CCSG treatment protocols since 1968 at our institution and have utilized Actinomycin D and radiotherapy, or Actinomycin D, Vincristine and radiotherapy in all patients.

The overall survival in this series correlates well with the stage of disease at the time of initial presentation. The trend of increased survival since 1968 is evident especially in Stages I and II, and compares well with data from the National Wilms' Tumor Study and other large series.[1-4] In addition to modern improved treatment protocols, improvement in survival may well be related to the advances in surgical and anesthetic techniques, postoperative care, and monitoring of postoperative treatment programs for problems

of toxicity. Survival in Stage III disease is still poor and appears worse than in Stage IV disease with isolated pulmonary metastases. Similar results have been documented in other studies.[1-4,10-12] The size or site of tumor did not correlate well with survival nor did age unassociated with stage.[3,13]

The high incidence of non-visualization upon initial intravenous pyelogram (20%) in this series is of interest. Other series where this parameter is noted report an incidence of 10-15% non-visualization and consider it a grave prognostic sign of vascular invasion.[3,4,14] In seven of our cases adequate explanation for nonvisualization was found secondary to vascular or pelvic invasion, parenchymal replacement, or extrinsic uretero-pelvic obstruction by tumor. In two others, no adequate explanation could be found. A similar interesting case was reported in 1947 by Ferris and Beare, in which there was no gross or microscopic invasion of vessels or collecting system at time of excision, but recurrence came in less than one year and appeared at the ipsilateral ureteric orifice.[15] The two deaths in our group were from perioperative complications. Thus, in contrast to the study of Kumar et al,[16] but in agreement with the work of Lalli,[13] non-visualization in this series did not necessarily carry a grim prognosis, even if there was gross invasion of the renal vein or renal pelvis.

Summary and Conclusions

Forty-nine cases of Wilms' tumor have been treated and followed completely from 1953 to 1976 inclusive. Prior to 1968, treatment of Wilms' tumor was not standardized and children received a wide variety of therapeutic regimens. Since that time, treatment has been coordinated by the protocols of the National Wilms' Tumor Study. Follow-up was complete in all 49 patients. Patients are divided into two groups, A and B, pre and post-1968, respectively, with 19 and 30 patients in each group.

The overall raw survival of the 49 cases to date is 67%. Six cases are less than two years post-initial resection and are excluded from the remainder of the survival statistics. Since 1968, minimum two-year survival after resection has been as follows: Stage I, 100%; Stage II, 82%; Stage III 0; Stage IV, 25%; Stage V, 0. There is no correlation of survival with age at the time of diagnosis in either group.

Of interest was an incidence of 20% non-visualization of the involved kidney on intial intravenous pyelogram. Of these nine cases, seven are alive and well today. Failure to visualize on intravenous pyelogram is relatively frequent and does not necessarily connote a grim prognosis.

Clinical stage at the time of diagnosis continues to be the best prognostic parameter in children with Wilms' tumor. Current combined therapy includes surgery, postoperative radiotherapy, and postoperative combination chemotherapy with Actinomycin D and Vincristine.

Acknowledgement

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Definitive Radiotherapy of Prostatic Cancer
A Progress Report

Ben M. Birkhead, M.D.

Louisville, Kentucky

A clinical trial, testing the efficacy of radiotherapy in the treatment of prostatic cancer, has been in progress at the University of Louisville Radiation Center since 1965. By January 1, 1977, a total of 130 patients had finished such a course of treatment. This report will summarize, to date, the status of these 130 men.

THE majority of patients were drawn from the metropolitan Louisville area. However, roughly a fourth were referred from considerable distances; in some instances, several hundred miles distant. Patients living in Louisville, or within a 100-mile radius of Louisville, have been followed at the Radiation Center, as well as by the referring physicians. Those patients living beyond that limit generally prefer to have their follow-up care with their local physician. He, in turn, advises us by mail or phone of the status of that patient.

The distribution of the patients by age is shown in Table 1. The average age of the patient population is 65 years. (Table 1)

Table 1

AGE DISTRIBUTION

Age	Number of Patients
40 - 49	3
50 - 59	24
60 -	69
70 - 79	32
80 - 89	2
TOTAL	130

Staging of the extent of the cancer was done at the initiation of radiotherapy according to the system devised by Whitmore[1] as follows:

Stage A: The clinically inapparent prostatic cancer, found incidentally . . . during examination of clinically removed prostatic tissue, and without evidence of local extension beyond the prostatic capsule or of metastasis.

Stage B: The clinically evident prostatic cancer, apparently confined within the prostatic capsule and without evidence of metastasis.

Stage C: The clinically evident lesion with apparent local extension beyond the prostatic capsule but without evidence of metastasis.

Patients were not upstaged because of the finding of an elevated acid phosphatase.

The distribution of the patients by Stage is shown in Table 2.

Table 2

STAGE DISTRIBUTION

Stage	Number of Patients
A	9
B	52
C	69
TOTAL	130

All 130 patients had adenocarcinomas. The cancers were of acinic origin in 127 patients; of ductal origin in 3 patients.[2]

Technique

Four basic radiotherapy treatment plans have been used, in sequence, during the tenure of this trial.

From 1965 - 1968, treatment was conducted by 360° rotational Cobalt therapy through a 7 cm × 7 cm portal to a central axis dose of 6600 rads administered over seven weeks. This plan gave a satisfactory dose to the prostate yet did not excessively irradiate the bladder and rectum. It was abandoned in 1968 because it was felt the dose to the regional lymph nodes was not adequate.[4]

From 1968 - 1970, treatment was conducted with Cobalt through anterior-posterior, parallel opposed, whole pelvic portals to a minimal tumor dose of 6000 rads in six weeks. This plan had

From the Radiation Center, 500 South Floyd St., Louisville, Kentucky.
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Table 3

RESULTS

Stage	#	Alive and NED*	Alive with Cancer	Dead of Prostatic Cancer	Dead ICD
A	9	7	—	—	2
B	52	38	3	4	7
C	69	41	9	12	7
Totals	130	86	12	16	16

*No Evidence of Disease = alive without clinically evident recurrent cancer

the advantage of giving a uniform dose to the prostate and to the regional pelvic nodes, but had to be abandoned because of an unacceptably high incidence of chronic radiation proctitis and cystitis.

From 1970 - 1972, the same basic plan was used but the time-dose relationship was altered to give 6000 rads in 30 treatments over nine weeks. The treatment was divided into three sets of ten treatments with a rest of ten days between sets. The incidence of chronic bowel and bladder complaints was considerably reduced but was still too high.

Since 1970, treatment has been given principally through anterior-posterior, parallel opposed, whole pelvic portals with 25 million volt (peak) x-rays generated in an Allis-Chalmers Betatron. A minimal tumor dose of 5400 rads is given in 27 treatments over eight weeks. The prostate and its immediately surrounding lymph nodes then receive an additional 1000 rads in one week through a straight-on, 7 × 7 cm perineal portal, with Cobalt. This presently used treatment plan achieves a good dosage distribution to both primary tumor and pelvic lymph nodes. To date, there have been no instances of serious bowel or bladder complaints associated with this treatment plan.[5]

Results

Radiotherapy has failed to control the cancer in 28 patients. Sixteen have died of prostatic cancer. Twelve are still living with recurrent cancer. The average interval from start of radiotherapy to detection of the recurrence was 19 months. By 36 months post-radiotherapy, 27/28 recurrences were manifest. Review of the histologies of the failed patients reveals the cancer was poorly differentiated in 15 patients; moderately differentiated in 11 patients; and well differentiated in only two.[6] There was failure to control the primary cancer in 12/18* patients. There was regional node failure, clinically demonstrated, in 7/28* patients. There was distant failure in 17/28* patients, with target organs being bone, liver, and lung in order of likelihood of involvement.

A total of 16 patients have died intercurrent deaths, free of prostate cancer at time of death. Second primary cancers accounted for eight deaths. Five patients died of cardiovascular causes. Two died of enteric fistulae directly related to radiation damage. One patient died of a gunshot wound.

To date, 86 patients are alive and free of clinically evident recurrent cancer after an average period of follow-up of 37 months. One-fourth of them are taking adjuvant estrogen treatment.[7]

Table 3 shows the fate of all the patients, by stage.

The present crude survival rate is 75%. The crude, disease-free survival rate is 66%. If the data are corrected for the intercurrent deaths, the corrected survival rate becomes 86%; the corrected disease-free survival rate, 75%.

Summary

The present status of an on-going clinical trial, testing the effectiveness of radiotherapy in the treatment of prostatic cancer, has been reviewed.

This communication should be regarded solely as a progress report. The period of observation is too short for any conclusive statement about the curative potential of radiotherapy in these patients.

To date, there has been local control of the

**The numerators add up to 36/28 because some patients failed in more than one category.*

primary tumor in 91% of patients treated. The corrected survival rate is 86%. The corrected recurrence -free survival rate is 75%. The survivors have been under observation for an average of 37 months at the time of this writing.

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Efficacy and Safety of Cefadroxil

W. E. Gordon, M.D.

Benton, Kentucky

Twice-a-day oral treatment with cefadroxil for acute uncomplicated urinary tract infection produced excellent results in comparison with q.i.d. administration of cephalexin. A cure rate of 100% was attained in both drug groups, and patients in the cefadroxil group had fewer side effects than those using cephalexin.

Introduction

A variety of cephalosporin broad-spectrum antibiotics is available in the United States today. Most are absorbed poorly from the gastrointestinal tract and must be given parenterally. Cephalexin and cephradine, which are available as oral preparations, have a half-life of 30 minutes[1] and 42 minutes,[2] respectively, and hence must be administered four times a day for maximum effectiveness.

Cefadroxil (Duricef®) is a new orally administered cephalosporin which has a half-life of 72 minutes,[1] i.e., about twice that of the other oral cephalosporins. It is chemically stable and acid resistant, and thus well absorbed following oral administration.[3]

Cefadroxil and cephalexin are excreted primarily through the urine.[1] A previous study comparing the pharmacologic and antimicrobial characteristics of cefadroxil and cephalexin reported similar peak concentrations of these drugs in the serum following ingestion of single 500 mg tablets.[3] The concentration of cefadroxil in the serum, however, was noted to be more sustained than that of cephalexin. Cefadroxil has been shown to compare favorably to cephalexin in susceptibility to beta-lactamase, serum-binding, stability in solution, and efficacy against induced bacterial infections in mice; but cefadroxil was more effective than cephalexin against *Str. pyogenes*-induced infections.[4]

A major indication for oral cephalosporins is treatment of most urinary tract infections, those caused by susceptible organisms. This double-blind study was designed to compare the safety and efficacy of cefadroxil given twice a day and cephalexin given four times a day, each when used in the treatment of acute uncomplicated urinary tract infections caused by sensitive strains of one or more of the following bacteria: *Escherichia coli, Proteus mirabilis, Aerobacter, Enterobacter,* and *Staphylococcus.*

Methods

A total of 60 adults with a diagnosis of acute uncomplicated urinary tract infections were initially enrolled in the study after their informed consent was obtained. The disease was considered uncomplicated if no structural abnormalities known to predispose to or permit persistence of an infection were thought to contribute to the etiology. Patients were classified either as "symptomatic," in which infections were accompanied by fever, constitutional symptoms, or typical clinical signs of urinary tract infection, such as back pain; or "asymptomatic," in which symptoms were absent but two positive urine cultures taken 24 hours apart indicated presence of infection. A positive urine culture was defined as one with 100,000 or more bacteria per milliliter of urine.

Patients excluded from the study were those who were pregnant, hypersensitive to cephalosporins or penicillin, or in whom diabetes or renal, hepatic, or serious cardiac abnormality was present. Nor could any patients participate whose baseline laboratory or bacteriologic culture indicated out-of-range clinical chemistry values or presence of cephalosporin-resistant bacteria. Finally, those who required other concurrent antibacterial therapy or who had such treatment within two weeks prior to this study were excluded.

Patients received orally administered cefadroxil 1000 mg b.i.d. or cephalexin 500 mg q.i.d., for a total daily dosage of 2000 mg each, in accordance with the randomized double-blind design. Patients receiving cefadroxil were given two 500 mg capsules for the first daily dose, followed by two placebo capsules for each of the second

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and third daily doses, and then two 500 mg capsules of active drug for the fourth daily dose. Cephalexin was administered in a 500 mg capsule along with one placebo capsule at six-hour intervals. A minimum treatment time of five days was required.

Physical and clinical laboratory examinations of every patient were made at the beginning and at the end of therapy. Clean-voided urine specimens were collected before treatment, between the second and fourth days of therapy, at five to nine days post-treatment, and again four to six weeks after cessation of treatment for evaluation of relapse or reinfection. Susceptibility to cefadroxil and cephalexin was determined by disc sensitivity testing of one or more causative pathogens isolated and identified in each urine culture. Susceptibility to the test drugs was established by a modified Bauer-Kirby-Sherris-Turck method, in which a 30 μg cefadroxil disc (for cefadroxil) or an appropriate cephalothin "class" disc (for cephalexin) were utilized. Organisms were considered susceptible if the zone of inhibition was at least 14 mm.

A cure was identified by good clinical response and urine culture performed five to nine days post-therapy, in which a count of 10,000 or fewer organisms per milliliter of urine was established. All treatment-emergent signs and symptoms were recorded throughout the study and an effort made to determine whether or not the reaction was drug-related.

Results

Of the 60 patients admitted to the study, 57 were included in the efficacy analysis. The other three patients were lost to follow-up. All 60, however, were included in the safety analysis.

Table 1 presents patient characteristics by drug group. Age, weight, and sex distributions were similar for the two treatment groups. More than 80% of the patients in each group were females. The diagnosis for 53 of the 57 evaluated patients was nonspecific urinary tract infection; the remaining four—all on cefadroxil—had cystitis. Pathogens identified by drug group in the total population are shown in Table 2. *E. coli* and *P. mirabilis* were the most common organisms found in the urine cultures of these subjects, together comprising over 90% of all the bacteria isolated. *Aerobacter, Staphylococcus,* and *Enterobacter* accounted for the other infections.

Table 1
PATIENT CHARACTERISTICS BY DRUG GROUP

	Cefadroxil	Cephalexin
Number		
Males	6	4
Females	25	25
Both	31	29
Age (years)		
Mean	45.8	42.5
Range	18-82	18-88
Weight (lb)		
Mean	143.1	142.9
Range	104-225	95-205
Duration of Illness (days)		
Mean	10.2	9.2
Range	2-90	2-90

Table 2
PATHOGENS IDENTIFIED BY DRUG GROUP

	Cefadroxil	Cephalexin
Escherichia coli	11	14
Proteus mirabilis	19	13
Aerobacter	2	1
Enterobacter	0	1
Staphylococcus	1	0

Mean duration of illness of the cefadroxil and cephalexin groups was 10.2 and 9.2 days, respectively, with the same range of 2 to 90 days indicated for each group. Patients were treated for a mean duration of 10.6 days in the cefadroxil group and 10.8 days in the cephalexin group. Cures, as defined by the protocol, were obtained in all 57 patients evaluated. Relapse or reinfection occurred in only one cefadroxil-treated patient and in two cephalexin-treated patients.

Side effects (Table 3) were reported by 12.9% (4/31) of the cefadroxil-treated patients and by 30.8% (8/26) of the cephalexin-treated patients. Symptoms common to both drug groups were nausea, vaginitis, dysuria, and frequency of urination. The primary difference in side effects between the two groups was the occurrence of vaginal itching and/or burning, reported by four cephalexin-treated patients (15.5%) but by none of the patients in the cefadroxil group.

Evaluation of pre- and post-treatment clinical chemistry parameters, which included hematology, blood chemistry, and urinalysis, did not indicate

any changes considered related to treatment in either drug group. Occasional outlying values did not fall into any pattern which could be associated with cephalosporin toxicity.

Discussion

Evaluation of the effects of two oral cephalosporin antibiotics—one, cephalexin, requiring q.i.d. administration, and the other, cefadroxil, newly developed and administered b.i.d.—reveal comparable efficacy in the treatment of acute uncomplicated urinary tract infections in these patients. A cure rate of 100% was achieved for all 57 patients evaluated for efficacy in this study. Only 5% (3/57) experienced relapse or reinfection; two of these three had received cephalexin.

Side effects occurred in only 20% (12/60) of the total population of both drug groups; most (8/12), however, were patients receiving cephalexin. The clinically significant difference between the two drug groups in this respect was the incidence of vaginal itching and/or burning, noted in 15% (4/26) of the cephalexin patients but in none of the cefadroxil patients. Such reactions are not uncommon to cephalosporins.

Table 3

INCIDENCE OF SIDE EFFECTS BY TREATMENT*

	Cefadroxil	Cephalexin
Vaginal itching	0	4
Vaginal burning	0	2
Nausea	1	1
Dysuria/frequency of urination	1	1
Vaginitis	2	1
Chills	1	0
Gastric irritation	1	0
Watery and swollen eyes	1	0
Stinging of the urethral meatus	0	1

*Side effects were reported by 4 patients receiving cefadroxil and by 8 patients receiving cephalexin.

The most important finding in this study was that twice-daily administration of one cephalosporin could achieve efficacy and safety at least comparable to the required four-times-a-day administration of another cephalosporin. This reflects the comparative bioavailability of these drugs, which indicated a half-life for cefadroxil of about twice that for cephalexin. Prior to the development of cefadroxil, dosage of the only available orally administered cephalosporin antibiotics was established at four-times-a-day schedules. This treatment schedule is widely considered to be the least successful form of oral administration in terms of patient compliance.

Data in this study indicate that cefadroxil is at least as effective as cephalexin, and may be associated with somewhat less vaginal and urethral irritation. At twice-a-day administration, the advent of cefadroxil heralds a new advance in the efficacious oral treatment of urinary tract infections by the cephalosporin class of antibiotics.

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Nonproprietary and Trade Names of Drugs

Cefadroxil—*Duricef.*
Cephalexin—*Keflex.*
Cephradine—*Anspore, Velosef.*
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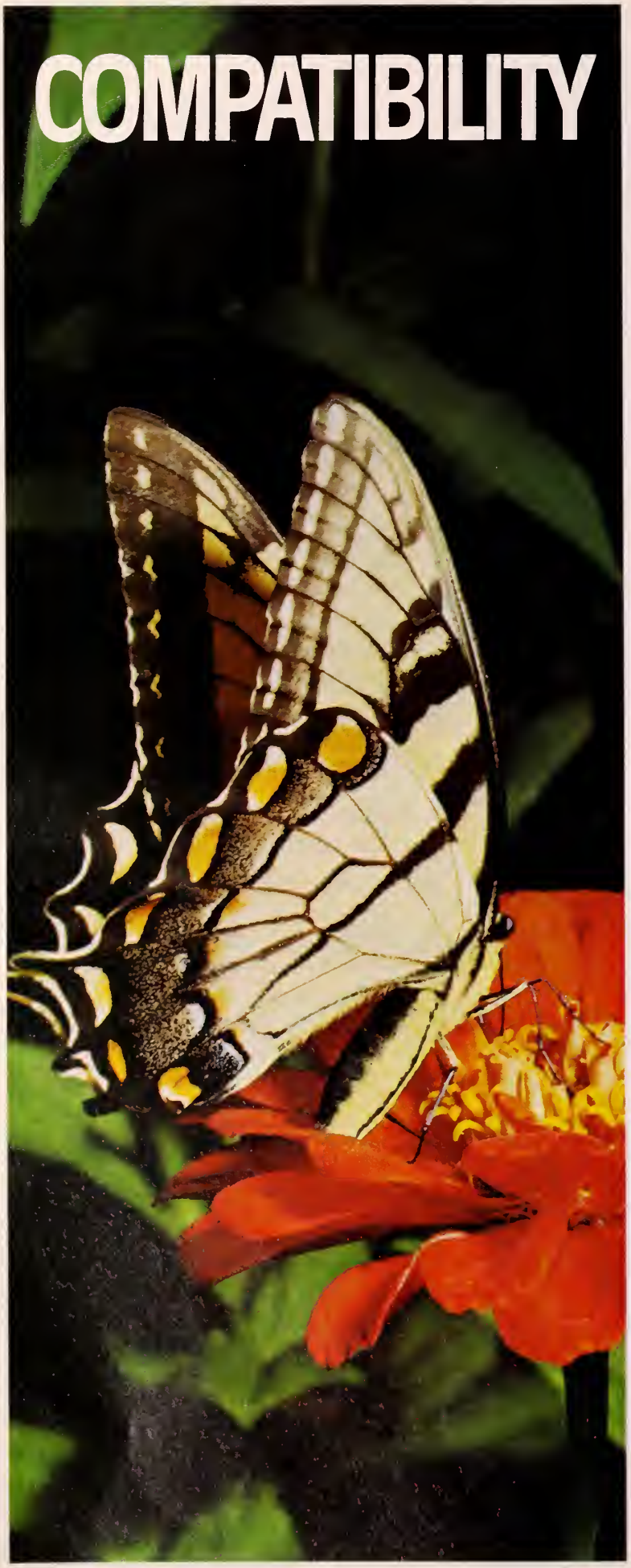

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GRAND ROUNDS

University of Kentucky College of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

Carcinoma of the Prostate

THERE are few areas in preventive medicine that require as much experience and judgment as the proper evaluation and treatment of prostatic adenocarcinoma. This neoplasm is a major widow-maker and among malignant tumors in males is second only to carcinoma of the lung in incidence. In 1977, there were approximately 60,000 new cases of prostatic adenocarcinoma in this country, an incidence ratio of approximately 120 per 100,000 men at risk. There are other malignant tumors of the prostate gland, namely transitional cell epithelioma, rhabdomyosarcoma, and squamous cell carcinoma, but these collectively account for only three per cent of malignancies of this organ.

Adenocarcinoma tends to be a disease of older men. It is rarely reported below the age of 34, and below the age of 50 it may be classified as unusual. The incidence of clinical prostatic cancer peaks in the eighth decade, and if a man were to live to the age of 80, there is a 50% chance that he would have microscopic foci of adenocarcinoma in his prostate. Sexual activity does not seem to be related to the incidence of carcinoma of the prostate.

Unfortunately, at the time of initial discovery more than half of the cases will have widespread metastases with only 5-10% of patients having the tumor actually confined to the prostate itself. In order to increase the early diagnosis of prostatic carcinoma, it is critical that every male 40 years of age or older have an annual digital-rectal examination with a high degree of suspicion on the part of the examiner. When any hard areas are found or when prostatism develops rapidly, a prostatic needle biopsy should be performed to rule out malignancy.

There are no early symptoms of carcinoma of the prostate due to its cryptic location. By the time dysuria, hematuria and symptoms of outflow obstruction occur, the tumor is almost always outside the capsule of the prostate and no longer curable. After cancer of the prostate has metastasized to bone it causes a severe degree of pain. The patient will almost always have anemia resulting in a pale sallow complexion as the tumor replaces the bone marrow. Even in the face of metastatic disease, the serum acid phosphatase, as now determined by enzymatic methods, is elevated only 75% of the time. More specific and accurate radioimmunoassay methods of determining serum levels of prostatic acid phosphatase are becoming available to facilitate earlier detection. In addition, the alkaline phosphatase may also be elevated as the tumor replaces the normal bone. The typical picture on x-ray is that of osteoblastic metastases, fluffy white depositions on pelvic, spine and rib x-rays. Osteoblastic metastatic lesions may be confused with Paget's Disease of the bone; in the former condition, the trabecular pattern of the bone matrix is lost, while in the latter, it is retained. Less frequently, lytic bone lesions are seen on x-ray with carcinoma of the prostate; these are manifestations of osteoblastic activity occurring in the path of the tumor infiltration and increased calcification. The bone scan will be positive in the presence of metastases but beware of false positive results in areas susceptible to arthritic changes. In advanced stages of the disease, pulmonary nodules may be seen on chest x-ray as the tumor spreads to the lung and varying degrees of hydronephrosis as it extends locally in the pelvis and blocks both ureters.

Urine cytology is presently of no value in the diagnosis of prostatic adenocarcinoma because this tumor usually starts in the posterior portion

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Presented at Surgical Grand Rounds at the University of Kentucky College of Medicine, Lexington.

of the gland and, even though it does spread into the urethra, the adenocarcinoma cells are not the exfoliative type in contrast to transitional cells.

The variable biologic expression and potential of prostatic carcinoma makes classification difficult. And yet, such classification is necessary if progress is to be made in determining the results of various treatment modalities. The size and extent of spread of this tumor is defined in four stages, A through D. Stage A is an incidental finding on transurethral resection or suprapubic prostatectomy of a microscopic focus of tumor. It is a small area within the gland which is not palpable on digital-rectal examination and causes no symptoms. It is usually low grade, but it can in rare instances be of high grade. Stage B is a tumor completely confined to the prostate and is palpable upon rectal examination. Periodic rectal examination is performed to pick up this type of nodule when it is still in the curative stage. At this stage, no urinary symptoms are present and the serum acid phosphatase is normal. The asymptomatic tumor can only be detected by digital-rectal examination. Unfortunately, a very small percentage (5-10%) of the patients we see with carcinoma of the prostate present in this fashion.

In Stage C the tumor has regionally spread outside the prostate into the pelvis and the seminal vesicles. It may cause urinary symptoms of prostatism and the serum acid phosphatase may be elevated. Again, the number of patients we see presenting in this stage is relatively small.

In Stage D the lesion is out of the pelvis, in the bones, lungs, lymph nodes, and other distant sites. As mentioned, the serum acid phosphatase is elevated in about 75% of these patients. Regrettably, this is the stage in which the greatest number of patients first present to their physician.

Treatment

Stage A tumors, which are found on histologic examination, are treated in two ways. The low grade tumors are managed with periodic follow-up and treatment is deferred as long as the tumor remains unchanged, which generally is the case with these low grade, Stage A tumors. If there is a high grade tumor, we may treat the patient with radical retropubicprostatectomy with or without associated pelvic lymphadenectomy and/or radiotherapy if the patient is otherwise healthy and has a 10-year or greater life expectancy. Radical prostatectomy entails an en bloc dissection with removal of the regional pelvic lymph nodes, excising the prostate from the bladder at the bladder neck, removing the seminal vesicles, transecting the prostate at the urogenital diaphragm and, finally anastomosing the membranous urethra to the bladder neck.[1]

Stage B patients are perhaps the most amenable to aggressive therapy. These patients are primarily treated by radical prostatectomy, again, if there is a 10-year life expectancy. About 10 years ago irradiation of the prostate and pelvic area came into vogue for Stage B and Stage C disease. Both interstitial irradiation and supravoltage external irradiation have been applied. Additionally, pelvic lymphadenectomy and implantation of radioactive I-125 into the retained prostate are achieving early results that are encouraging. Recent reports have shown favorable survival rates using the modalities with results comparable to those of radical surgery.[2,3] A radiotherapist well-versed in the techniques and methodology is essential when this course is chosen.

About 80% of adenocarcinomas are androgen-dependent.[4] Exogenous estrogens suppress the pituitary gonadotropins. This in turn suppresses the production of testosterone by the Leydig cells of the testicle. Orchiectomy surgically accomplishes the same result of removing testosterone without the side-effects and complications of estrogen therapy. These methods of androgenic ablation may be used in patients with Stage B disease who are not candidates for radical prostatectomy or irradiation. But generally at this stage, non-surgical therapy is reserved until the patient becomes symptomatic.

In Stage C tumors, the primary mode of therapy is estrogens and/or orchiectomy. Irradiation has been advocated, but the statistics are equivocal. Radical prostatectomy has been advocated by a few people, but since the tumor is extracapsular, cure rates from surgery are no better than those resulting when other modalities are employed.

The most effective treatment at the present time for Stage D prostatic carcinoma is estrogens and/or orchiectomy, although the results are largely palliative. Diethylstilbestrol 1 mg/day is the recommended daily dosage, with the upper limit being 3 mg/day. The patient may live for many years in symbiosis with his tumor with little or no progression of the disease. Sometimes

no therapy is indicated, especially in patients past the age of 75 where the tumor tends to grow very slowly.

About 50% of men aged 65 claim that they are potent. If the prostate is irradiated for carcinoma with the high (7,000 R) dosage that is recommended, about 60% of those who claim potency beforehand are impotent afterwards. About 20% of those who are initially potent will be potent after orchiectomy and stilbesterol. Following radical prostatectomy, impotence is almost universal.

Results using non-hormonal chemotherapy for Stage D disease have been generally disappointing. However, there are recent reports of Estracyte giving subjective improvement to patients with advanced prostatic cancer.[5]

Once the patient with Stage D disease becomes refractory to estrogens and orchiectomy, other forms of therapy are strictly palliative and include stilphostrol, hypophysectomy, adrenalectomy and P^{32} with Halotestin. Stilphostrol, a phosphorylated estrogen compound has been helpful in relieving bone pain which may result from metastatic disease. Once in the cell, the compound releases its phosphate radical which inhibits the mechanics of the cell, thus impeding tumor growth. Trans-sphenoidal hypophysectomy is a steriotactic procedure designed to ablate the pituitary which in turn removes the stimulation by ACTH of the adrenal gland, where there is a small amount of androgen produced. The adrenal androgens, etiocholanolone and androstenedione, have about 1/30th the androgenic potency of testosterone, but removal of this small amount of hormone may offer some relief to the patient. Bilateral adrenalectomy has the same effect, i.e., it removes the adrenal androgens. Because the patient must be maintained on steroids afterwards, it has not been a popular form of treatment. Medical adrenalectomy with oral glucocorticoids has also been tried. P^{32} radioactive phosphorus plus Halotestin, a synthetic oral androgen which incorporates the P^{32} more actively into the bone, has in selected cases given dramatic relief of bone pain.

As the tumor grows into the urethra and causes prostatic obstruction, transurethral resection will relieve the obstructive symptoms. Once the tumor has started to grow through the external sphincter, permanent suprapubic cystostomy is the best approach since resection in the region of the external sphincter is likely to result in urinary incontinence. When all these therapeutic modalities fail, potent analgesics may be the sole source of relief of the severe bone pain which these patients experience.

Five-year survival data for carcinoma show that patients with Stage A disease will have a life expectancy similar to that of the normal population provided the tumor is not high grade. About 70% of patients with Stage B disease can expect to be alive five years after the discovery of the tumor. For Stage C and D tumor, the five-year survival percentages are in the range of 50% and 25% respectively. One can see that this tumor is basically slow in its progression. Additionally, the older the patient the slower tumor growth seems to be.

J. William McRoberts, M.D.
John J. Mulcahy, M.D.

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EDITORIAL

Guest Editorial

Views of An Elected Official

The elections throughout the state last November produced some interesting results and saw increased participation by the medical profession in certain areas. Members of KEMPAC and AMPAC have urged us to get involved. Here is an opinion of a qualified observer outside of medicine who was recently elected Judge of Jefferson County.

THANK you for this opportunity to address the members of the Kentucky Medical Association on matters of concern to you and to county government. First, I would like to thank those of you who involved yourselves in the last campaign, whether you were working on my behalf or that of my opponent. The important thing is that you cared enough to put your time or money on the line for your beliefs.

There are far too many people who wait until a presidential election is imminent, and one or the other of the candidates captures their fancy with catchy phrases or an attractive personality, before they concern themselves with the political process. This is a serious mistake.

The strength of the political parties lies not in Washington, not in the White House, but in Louisville, Keokuk, and Great Falls. Politics MUST be a grass-roots process if democracy is to work the way our forefathers intended it to work. Indifference at the local level leads to demagoguery—and a sleeping nation can awaken to chaos at the top. We have seen many examples of this throughout history, with governments going through a revolving door while outraged and helpless citizens despair of regaining their rights. Yet, they themselves are to blame. They weren't interested—until it was too late. It can't happen here? I hope not.

I know you are seriously disturbed by some of the present trends in legislation relating to the medical profession, and I share your concern. I must warn you, however, that unless you participate in local politics and support the philosophy that most nearly resembles your own, you will pin your hopes on a sympathetic presidental candidate in vain. Political organizations are built over a period of years, and built by doctors, housewives, laborers . . . whoever CARES enough to furnish the money and muscle. They are realistic. They know they may not have a candidate with whom they agree 100%, but they are willing to work for basic principles. We rarely can afford the luxury of the hair-splitting.

In practice, what can you do? Right now the General Assembly is in session, and I would like to hear your views on pending legislation. If you have not participated in government before, this is a good place to start. Make it your business to find out what is going on in Frankfort, and then let us hear from you.

I urge you to rethink your priorities and to get seriously involved in the elective and legislative process. Your community, your profession, and the future of your country are too important to leave to chance.

MITCH MCCONNELL
Judge of Jefferson County

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Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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MATERNAL MORTALITY

From the Files of the KMA Maternal Mortality Study Committee

—Edited by John W. Greene, Jr., M.D.

Case 10-74. This case involves a 17-year old, married, white, Gravida 3, Para 2, LMP, October 20, 1974. Her husband was in an Ohio penitentiary and claimed she was raped. She missed her menstrual period in November and saw a physician who performed a pregnancy test which was positive. She had an abortion at a Cincinnati clinic on December 6, 1974.

According to the patient, she had severe pain following the procedure, but was asked to leave after one to two hours. She was given Tetracycline 250 mg four times a day. During that night, in addition to the abdominal pain, she had continued vaginal bleeding and a temperature elevation. The next day she noticed blood in her sputum. The fever continued with general malaise and anorexia. On the third day after the abortion, she vomited once, the abdominal pain became more severe and the fever was described as "worse". The patient was seen in the emergency room at 1:05 a.m., December 9, 1974. Initial WBC was 14,000 with 90 segs, 5 lymphs, 5 mons; RBC 4.39, 13.5 Hb. Examination revealed a developed, nourished girl in severe abdominal pain with high fever (103). Positive findings were limited to the abdomen, which was very tense with generalized tenderness; more over the lower portion. She had rebound tenderness over the lower abdomen. The bowel sounds were described as normal. Pelvic exam revealed the cervix soft and very tender. No masses were felt over the adnexa. The uterus seemed slightly enlarged and soft. The impression was acute endometritis, rule out septicemia. She was admitted and started on 1000 cc D5W every eight hours with 1 gm Keflin every six hours.

Examination by her physician on the morning of the 9th revealed a temperature of 103. She was diffusely tender over the lower abdomen from the umbilicus downward; however, she had normal bowel sounds. Vaginal examination revealed pus extruding from the cervix. The cervix was quite tender on motion, with uterine enlargement.

She required Demerol IM for pain, received an injection at 5 a.m. on the 10th. According to the nurse, she didn't appear ill and was in no distress at the time besides the pain. She was found dead in bed at 6:45 a.m., December 10, 1974.

The coronor was called and an autopsy was obtained. The autopsy showed fluid present in both lungs. No old or recent infarcts were demonstrated; no anti-mortem thrombi were present.

Examination of the vagina was unremarkable. The uterus was retroflexed, enlarged 2 cm above the symphysis. Its serosal surface was uniformly reddish blue with a boggy feeling; along the anterior surface there was a suggestion of crepitance. The ovarian veins were enlarged but contained only postmortem clots. The cervix was grayish blue with yellowish-red purulent exudate oozing from the oz. *The uterus was opened and the intact fetus was within the membranes* it was *the size of a 12-week gestation.* The implantation site was high along the posterior surface of the uterus. Just below this site the endometrium was shaggy, yellowish-red and appearing necrotic. Anterior to the implantation site the myometrium appeared ragged and hemorrhagic. No evidence of perforation was demonstrated.

Blood cultures were taken in addition to vaginal and uterine cultures, they grew anaerobic streptococcus, vaginal culture grew staph epidermitis. Microscopic examination of this section of the uterus revealed severe acute inflammatory response. The blood vessels were all dilated and

engaged; many contained septic thrombi composed of clusters of cocci within fibrin mesh work and some within polymorphonic clear leukocytes.

Comments

The Committee on Maternal Mortality classified this a direct obstetric death with preventable factors. It was noted by the Committee that voluntary interruption of pregnancy does carry risk even in the modern hospital setting. It was felt that this case represents one of overwhelming sepsis in which it was not ascertained that the uterus was emptied of its contents and there was "too little—too late" therapy rendered. Aggressive therapy ascertaining that the uterus was empty as well as antibiotic therapy should have been instituted at an earlier time. The fact that she had severe pain following the procedure was indicative of problems and when she maintained an elevated temperature more aggressive therapy was indicated. A classic paper depicting this problem and its management is that of Studdiford, W. E. and Douglas, G. W., "Placental Bacteremia: Significant Finding in Septic Abortion Accompanied by Vascular Collapse" in the *American Journal of Obstetrics and Gynecology* 71:842, 1956.

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LOOKING AHEAD

June 7-9 Emergency Medical Care Seminar, Executive West, Louisville
June 17-22 AMA Annual Meeting, St. Louis
September 24-28 KMA Annual Meeting, Hyatt Regency, Lexington
October 14 Regional Meeting, American College of Physicians, Lexington

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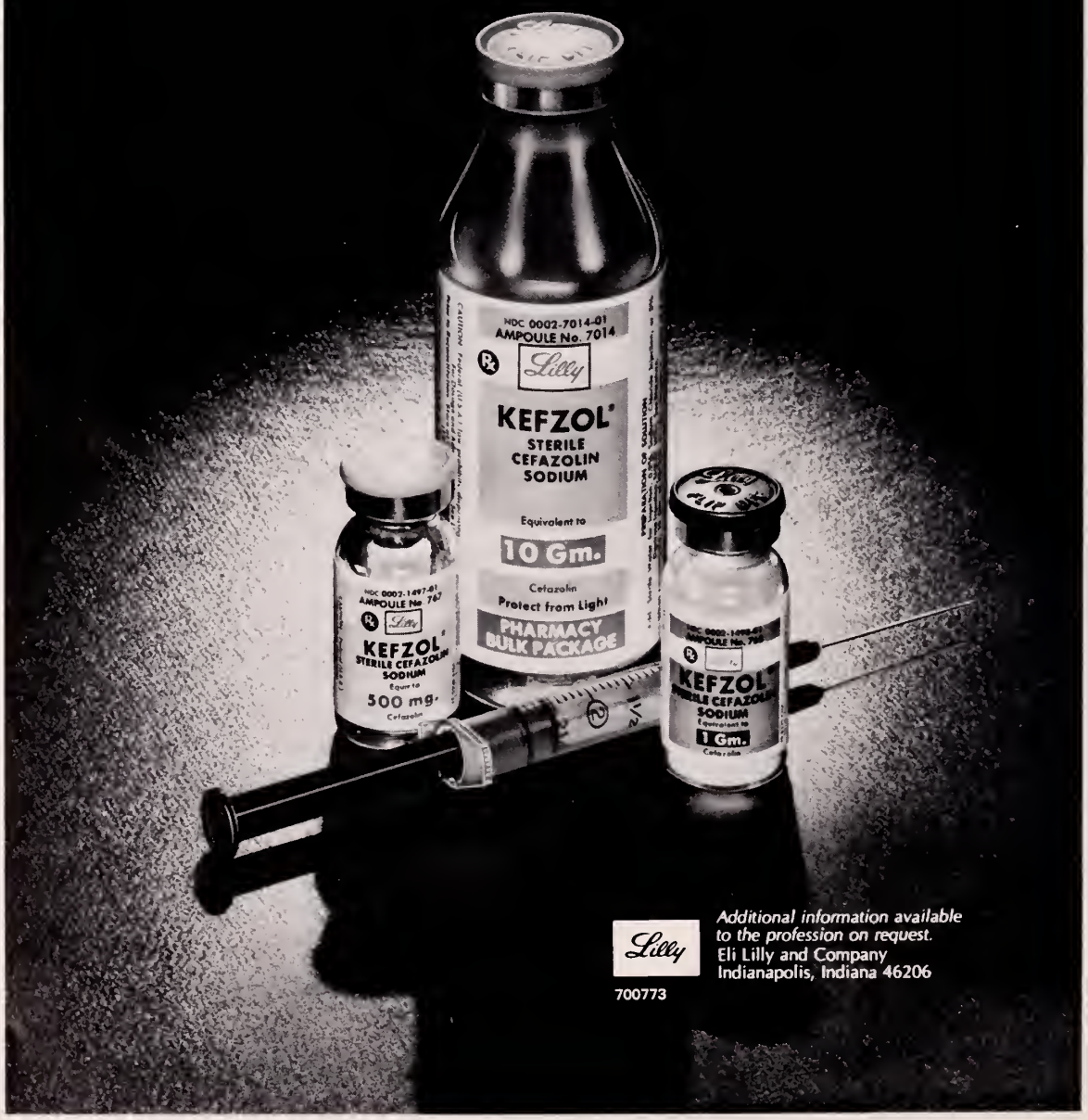

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ASSOCIATIONAL NEWS

8th Emergency Medical Seminar Set for June 7-9

June 7-9 are the dates for the 1978 Emergency Medical Care Seminar to be held at the Executive West Hotel, Louisville. The Eighth Annual Seminar will, for the first time, be held in conjunction with the Commonwealth of Kentucky's Emergency Service Conference.

The clinical segment, presented by KMA through the work of the Committee on Emergency Medical Care, will be held June 7 and 8. The administrative session is scheduled for June 8 and 9. Registration for the workshop is $15 per day.

CME credit will be applied for from the AMA, the Kentucky Academy of Family Physicians, the American Academy of Emergency Physicians, the Kentucky Nurses Association, and the American Registry for Emergency Medical Technicians.

KMA To Sponsor Workshops During April

Establishing Yourself in Medical Practice Workshop will be held April 25-26 at the Ramada Inn-Bluegrass Convention Center in Louisville. Designed for senior residents preparing to enter private practice, the two-day program will deal with personnel problems, patient flow techniques, physical aspects of the medical office, clinical and financial paperwork, practice location, and legal problems. Registration is limited, therefore those interested should register as soon as possible. For further information, contact the KMA Headquarters Office.

Negotiations Seminar, scheduled for April 26-27 in Louisville, is co-sponsored by KMA and AMA and is designed for the physician who routinely must deal with hospital boards, HSA's, third party carriers, and state and federal government agencies. Again, registration is limited, and those interested should contact the KMA Headquarters for further information.

Twenty-third Spring Conference Being Held by Lexington Clinic

The 23rd Annual Spring Clinical Conference presented by the Lexington Clinic will be held April 6. The 1978 Conference will deal with "Specialty Problems in Primary Care."

Guest lecturers will join with members of the Lexington Clinic staff in presenting the day-long session, which will begin with registration at 8:30 a.m. P. Frederick Sparling, M.D., Professor of Medicine and Chief, Division of Infectious Diseases at the University of North Carolina, will deliver the Carl Fortune Lecture. He will speak on "New Concepts in Management of Gonorrhea and Other Common Sexually Transmitted Diseases."

For further information, contact Phillip Martin, Lexington Clinic, 1221 South Broadway, Lexington, Kentucky 40504, or call 606-255-6841.

RKMSF Accepting Applications For Scholarship Loans

The Rural Kentucky Medical Scholarship Fund is now accepting applications from medical students who are residents of Kentucky and have been admitted to one of Kentucky's medical schools, according to G. L. Simpson, M.D., Chairman of the Fund's Board of Trustees.

The Fund, created in 1946 as a means of providing a better distribution of physicians in the rural areas of Kentucky, now has 208 physicians in practice in 87 counties with 28 serving in designated critical counties. Since its beginning, the Fund has loaned over $1-1/2 million.

A freshman student may now borrow up to $4,000 (a $500 increase over 1977) provided he will agree to practice in any of over 100 rural counties of the Commonwealth.

The Board of Trustees approved a total of 51 new and renewal loans for the 1977-78 school year and also granted three Establish Practice loans for a total loan amount of $200,500.

Doctor Simpson, in noting the success of the program over the past 31 years, expressed particular appreciation for the support of Governor Julian M. Carroll, the Department of Human Resources, and the members of the Kentucky General Assembly.

Sports Symposium To Highlight Injury Prevention, CME Credit

"Prevention of Sports-Related Injury," will be the theme of the Seventh Annual Medical Aspects of Sports Symposium to be held April 10-11 at the Hyatt Regency Hotel in Lexington.

Nationally recognized authorities participating on the program include Joseph S. Torg, M.D., Director, Temple University Center for Sports Medicine, Philadelphia; Allan J. Ryan, M.D., Editor-in-Chief, *The Physician and Sports Medicine,* Minneapolis; and Robert J. Robertson, Ph.D., Director, Human Energy Research Laboratory,

University of Pittsburgh. Fran Curci, football coach of the University of Kentucky, as well as the team physicians of University of Kentucky's football and basketball teams, will also appear on the program.

Directed toward high school and college coaches and trainers, team physicians, family practitioners, and orthopedists, the symposium is acceptable for 16 credit hours in Category I of the AMA Physician's Recognition Award and 16 hours of prescribed credit from the American Academy of Family Physicians.

Registration ($65 for physicians) may be made by contacting Ms. Joy Greene, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Scientific Exhibits Deadline Is July 1, 1978

Physicians interested in presenting a scientific exhibit at the 1978 KMA Annual Meeting are urged to make their plans soon, according to Richard A. Kielar, M.D., Chairman of the KMA Scientific Exhibits Committee.

Application for space should be received by July 1, 1978, at the KMA Headquarters Office. Scientific exhibits are supported and welcomed as a facet of continuing postgraduate education and credit can be obtained from the Kentucky Academy of Family Physicians and the AMA.

An application blank was printed in the February, 1978, issue of *The Journal*, page 92. Further applications will appear in subsequent issues of *The Journal* and may be obtained fom the KMA Headquarters Office.

Nominations Being Accepted For KMA Awards

Fred C. Rainey, M.D., Elizabethtown, Chairman of the KMA Awards Committee, announces that the Committee is now accepting nominations for the Kentucky Medical Association Award and the Distinguished Service Award.

The KMA Award is designed to honor an outstanding layman and the Distinguished Service Award honors the outstanding physician of the year. The awards are presented annually at the President's Luncheon during the KMA Annual Meeting in September.

Nominations for awards should be forwarded to the KMA Headquarters Office and marked: "Attention: Awards Committee."

1978 KMA Annual Meeting To Be Held Sept. 24-28 at Hyatt Regency/Lexington Center

The 1978 Annual Meeting of the Kentucky Medical Association will be held September 24-28 at the Hyatt Regency/Lexington Center. Due to scheduling problems in Louisville, the meeting place was changed from Louisville to Lexington.

Future issues of *The Journal* will highlight program participants, session themes, and specialty meetings. Reservations should be made as early as possible. A form is included here for your use in making room reservations with the Hyatt Regency Hotel, the Annual Meeting Headquarters Hotel. The form should be sent to the:

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	1 BR Suite	75-85-130
	2 BR Suite	120-160-215

If all rooms in the requested rate category are already reserved, the next available rate will be assigned. Making your reservation early will assist us in providing the type of room you request.

Date of Arrival _____

Departure _____

Check-in Time: 2:00 p.m.

Check-out Time: 12 Noon

Name _____

Address _____

_____

_____

Name(s) of additional person(s) sharing room

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_____

Reservations must be received by _____
September 9, 1978

Reservations will be held until 6:00 p.m. on day of arrival unless one nigh deposit is received, or guaranteed credit card.

_____ **Hold until 6:00 p.m. or**

____ **Reserved with deposit of $** ____

_____ **Bill my credit ca**

American Express # _____

Carte Blanche # _____

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THE PHYSICIAN'S COMPUTER DATA SYSTEM, by MICROTECH.

Cancer Update in the Parks Initiated by Ky. Div., ACS

The American Cancer Society, Kentucky Division, will conduct physician's conferences in five of the Commonwealth's state parks this year. To be held on Saturdays from 1 to 5 p.m., these conferences will deal with recent changes in cancer control.

The "Cancer Update in the Parks," will be conducted at:

Resort Park	Date	Topic
Barren River Lake	April 8	Colorectal Cancer
Kenlake	April 22	Gynecological Cancer
General Butler	May 20	Childhood Cancer
Carter Caves	June 3	Management of Patient with Disseminated Cancer
Jenny Wiley	June 24	Skin Cancer

Room reservations may be made by contacting the appropriate state park 583-9796 in Louisville, 252-4913 in Lexington, 261-2643 in Covington, or 1-800-372-2961 from any other location in Kentucky.

Application for continuing education credit is being made. For further information and registration contact American Cancer Society, Kentucky Division, 1169 Eastern Parkway, Louisville, Kentucky 40217. Registration closes one week prior to each respective conference.

Trustees' Report

SEVENTH TRUSTEE DISTRICT
William H. Keller, M.D., Frankfort

Each two years at this time Frankfort is humming with legislative activities, many of which affect organized medicine. Because of the large volume of material under consideration by the General Assembly and the very able reporting KMA officers and staff and the various media have done I will not attempt to enlarge upon their efforts.

Rather, I choose to direct my comments toward an area which affects most, if not all Kentucky's hospitals, practicing physicians, third-party carriers, and a large number of patients. King's Daughters Memorial Hospital in Frankfort, where I practice, like many other facilities in the state, is overcrowded, in need of more beds, and unable to obtain authorization to proceed with much needed construction in the near future due to governmental regulations. Much effort has been spent trying to resolve this problem.

One means of lessening the crowding of many Kentucky hospitals may be utilization of more pre-admission testing of patients whose medical circumstances (mainly elective admissions) will permit this. Several desirable benefits may be realized. First, hospital in-patient days can be reduced if many lab studies such as EKG'S, x-rays etc. . . ., are done on an out-patient basis in cases where patients are scheduled for admission, but with the cost of the tests being incorporated with the patient's hospital bill. Second, shortening a patient's hospital stay by a day or more should result in lowering costs for all concerned parties. Additionally, results of pre-admission studies should be more complete and more readily available than those done on an in-patient basis. This then, should help reduce significantly last-minute cancellation of cases already on surgical schedules, and thus free more beds for other patients.

As of this time, to the best of my knowledge the only third-party carriers officially recognizing the value of this system and incorporating it in their programs of health care provision are Blue Cross-Blue Shield and Medicare-Medicaid. These two groups provide coverage for some 53.6% of Kentucky's 3.4 million population. The remainder of the state's population is covered by other private carriers or has no insurance.

In years past KMA has worked with Blue Cross-Blue Shield to design and implement a pilot study to investigate the potential value of pre-admission testing. The results of their efforts were not encouraging. In order to effectively, fairly establish such a system, there must be general agreement that it is needed, and definite guidelines must be established in advance of promoting the program which ensure that abuses won't negate the potential gains. Moreover, physicians must be educated to recognize the values of the system and how to utilize the system to the advantage of all concerned. I submit that it is appropriate for KMA, with input from the Commissioner of Insurance, to renew investigative efforts to study the feasibility of such a program. Certainly, in this era of consumerism and cost-consciousness, we should endeavor to shorten hospital stays, utilize beds more effectively, and reduce health care costs where possible without sacrificing quality care.

TENTH TRUSTEE DISTRICT
James B. Holloway, Jr., M.D., Lexington

The Tenth District Trustee is looking forward with a great deal of anticipation to the Annual Meeting of the Kentucky Medical Association which will be held September 24-28, 1978 in Lexington at the Hyatt Regency. Thus far, cooperation with the Hyatt Regency has been exemplary. While it is anticipated that you will probably find your expenses higher during this meeting than previously, I hope that you will find the new shopping mall, the convention center, the meeting rooms, and food will more than make up for this added expense.

The Fayette County Medical Society, the Fayette County Medical Auxiliary, and your Trustee will be making special plans for you and your family, including special tours, to see that this Annual Meeting will be a memorable one for you.

Did you know . . .

The new CHAMPUS carrier for Kentucky is Wisconsin Physicians Service Insurance Corporation (Wisconsin Blue Shield). The WPS plans to develop a regular service representative program in the state and any questions on CHAMPUS claims should be directed to WPS, 1717 W. Broadway, Madison, Wisconsin 53713 or 608-221-4711.

* * * * *

Over 100 bills of concern to organized medicine have been considered by the Kentucky General Assembly which is now in its last days of activity. A KMA office has been maintained in Frankfort throughout the session and all Trustees and Legislative Key Men have been apprised weekly of the status of important bills.

* * * * *

The public shows its greatest confidence in the "people running medicine," according to a Harris Survey taken in late 1977. Fifty-five percent of the public said it has "a great deal of confidence" in medical leadership, compared to 42% in a 1976 survey. Scoring second to medical leadership was higher education with 41%. An earlier Harris Survey, showed that 73% felt medicine's leaders "really know what people want." Sixty-nine percent thought so in 1975.

Members in the news

NEW MEMBERS

BARREN
Gilroy L. Daley, M.D., Glasgow

BOONE
John P. Schmitz, M.D., Florence
Richard Sheridan, M.D., Florence

BRECKINRIDGE
George J. Neff, Jr., M.D., Irvington

DAVIESS
Leslie M. Riherd, M.D., Owensboro

FRANKLIN
George F. Hromyak, Jr., M.D., Frankfort
Edward Leslie, M.D., Frankfort

HARLAN
Samir Guindi, M.D., Harlan
Narendra D. Karmal, M.D., Harlan
Yung Poe Lee, M.D., Harlan

HENRY
Steven D. White, M.D., Campbellsburg

HOPKINS
John R. Brewer, M.D., Madisonville

JEFFERSON
William B. Lockwood, M.D., Louisville

LETCHER
Abubakar H. Tidal, M.D., Whitesburg

MADISON
Terry O. Harrison, M.D., Richmond

PENNYRILE
Emmanuel J. Battah, M.D., Hopkinsville

TAYLOR
Robert S. Shipp, M.D., Campbellsville

HONORS BESTOWED

Thomas Wiegert, M.D, Lexington, has been named Chairman of the Department of Family Practice at the University of Kentucky College of Medicine. A member of the U of K faculty since 1975, Doctor Wiegert also serves as the Associate Dean for Primary Care.

Kirby I. Bland, M.D., Louisville, was recently awarded a "Junior Faculty Clinical Fellowship" by the American Cancer Society, Inc. Doctor Bland is an instructor in the Department of Surgery at the University of Louisville School of Medicine.

Hiram C. Polk, Jr., M.D., Louisville, has been elected to serve as the American Board of Surgery's representative to the Residency Review Committee. Doctor Polk is Professor and Chairman of the Department of Surgery at the University of Louisville.

Headquarters Activity

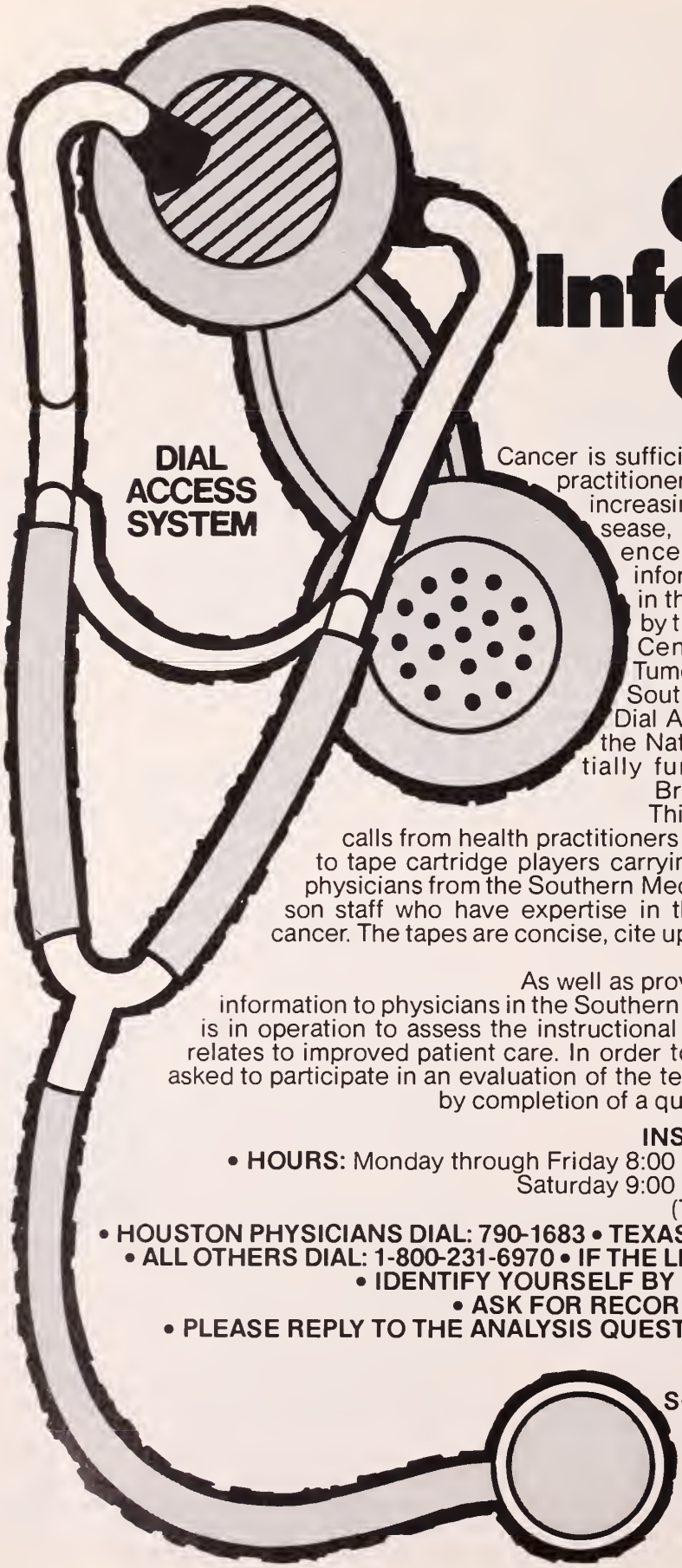
FEBRUARY

1 Ad Hoc Committee on Mobile Diagnostic Health Services, Frankfort
2-3 Annual Federation of State Medical Boards, Chicago
5 AMA Conference on Education, Chicago
6 *Journal* Editors Meeting, Louisville
9 Technical Advisory Committee on Physician Services (Title XIX), Louisville
Ad Hoc Committee on HSA's, Louisville
9-12 State Chief Executives Meeting, Miami
14 Committee on State Legislative Activities, Frankfort
16 Ad Hoc Committee on Mobile Diagnostic Health Services, Frankfort
23 Membership and Placement Services Committee, Louisville

MARCH

1 Judicial Council, Louisville
2 Commission to Study Health Costs, Louisville
8 Budget Committee, Louisville
Cancer Committee, Louisville
Executive Committee, Louisville
9 Board of Trustees, Louisville
Continuing Medical Education Committee, Louisville
13 *Journal* Editors Meeting, Louisville

SMA Cancer Information Center



Cancer is sufficiently prevalent that it touches every practitioner directly or indirectly. To facilitate the increasingly complex management of this disease, an easily accessible source of reference data is needed. This much-needed information is being supplied to physicians in the Southern Medical Association area by the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute, in cooperation with the Southern Medical Association. Known as Dial Access, this system is an outgrowth of the National Cancer Act of 1971 and is partially funded through the Cancer Control Branch of the National Cancer Institute.

This system provides toll-free telephone calls from health practitioners in all 17 states through 5 WATS lines to tape cartridge players carrying some 350 narrations authored by physicians from the Southern Medical Association and the M.D. Anderson staff who have expertise in the management of various types of cancer. The tapes are concise, cite up to three references, and have author identification.

As well as providing cancer management reference information to physicians in the Southern Medical Association area, the project is in operation to assess the instructional value of this and similar systems as relates to improved patient care. In order to accomplish this last, callers will be asked to participate in an evaluation of the technique and information transmitted, by completion of a questionnaire mailed to first-time users.

INSTRUCTIONS FOR USE OF SYSTEM

• **HOURS:** Monday through Friday 8:00 AM—1:00 PM Central Standard Time
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For Free Catalog, Write:
SOUTHERN MEDICAL ASSOCIATION
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2601 Highland Avenue
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GLASGOW	Happy Valley Center	409 Happy Valley Rd.	651-5113

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ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) ha demonstrated anthelmintic activity agains *Enterobius vermicularis* (pinworm) and *As caris lumbricoides* (roundworm). The anthe mintic action is probably due to the neurc muscular blocking property of the drug.

Antiminth is partially absorbed after an orc dose. Plasma levels of unchanged drug ar low. Peak levels (0.05-0.13 μg/ml) are reache in 1-3 hours. Quantities greater than 50% c administered drug are excreted in feces c the unchanged form, whereas only 7% or les of the dose is found in urine as the unchange form of the drug and its metabolites.

Indications. For the treatment of ascarias (roundworm infection) and enterobiasis (pir worm infection).

Warnings. *Usage in Pregnancy:* Reproductic studies have been performed in animals an there was no evidence of propensity for han to the fetus. The relevance to the human is n known.

There is no experience in pregnant wome who have received this drug.

The drug has not been extensively studie in children under two years; therefore, in th treatment of children under the age of tw years, the relative benefit/risk should be co sidered.

Precautions: Minor transient elevations SGOT have occurred in a small percentage patients. Therefore, this drug should be use with caution in patients with preexisting liv dysfunction.

Adverse Reactions. The most frequently e countered adverse reactions are related to th gastrointestinal system.

Gastrointestinal and hepatic reactions: a orexia, nausea, vomiting, gastralgia, abdom nal cramps, diarrhea and tenesmus, transie elevation of SGOT.

CNS reactions: headache, dizziness, drow ness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children ar Adults:* Antiminth Oral Suspension (50 mg pyrantel base/ml) should be administered in single dose of 11 mg of pyrantel base per l of body weight (or 5 mg/lb.); maximum tot dose 1 gram. This corresponds to a simplifi dosage regimen of 1 ml of Antiminth per 10 l of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspe sion may be administered without regard ingestion of food or time of day, and purgi is not necessary prior to, during, or after the apy. It may be taken with milk or fruit juices

How Supplied. Antiminth Oral Suspension available as a pleasant tasting carame flavored suspension which contains the equi alent of 50 mg pyrantel base per ml, suppli in 60 ml bottles and Unitcups™ of 5 ml in pac ages of 12.

More detailed professional informatic available on request.

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New York, New York 10017

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Highly effective
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Non-staining
Economical
Pleasant tasting

Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION

a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

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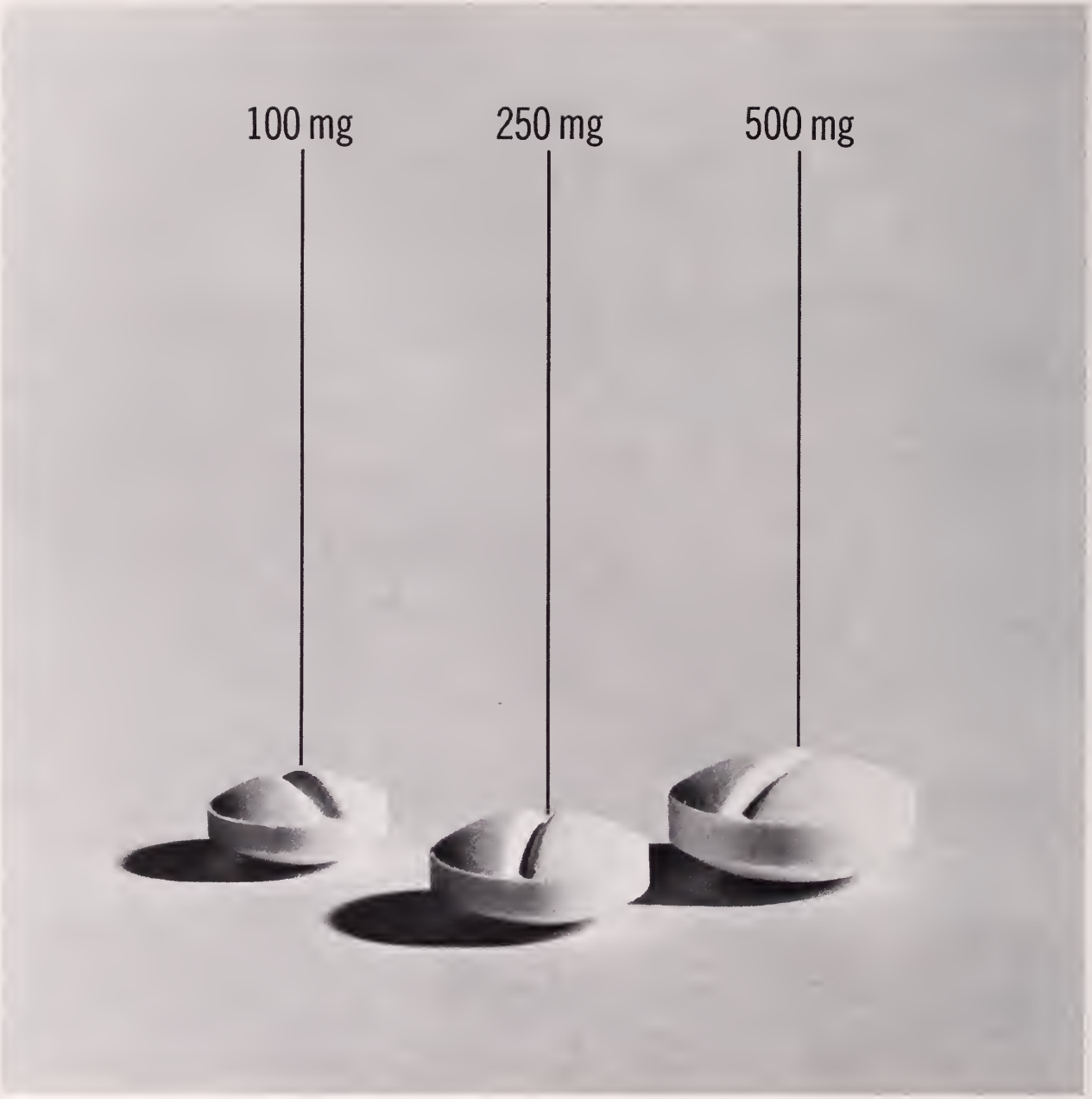

Tolinase®
tolazamide, Upjohn

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Upjohn

J-5695-6

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VALIUM® (IV) (diazepam)

can effectively relieve anxiety and its somatic symptoms.

Initial calming in hours

Your anxious patient will be reassured by the prompt action of Valium. It's immediate, tangible proof that the medication is working.

Significant improvement in days

Noticeable improvement of anxiety symptoms is usually evident within the first few days of therapy.

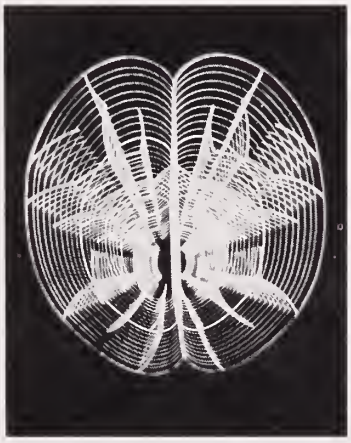
Patient response you know, want and trust

Valium offers clinical effectiveness and a wide margin of safety, which makes it a prudent choice for treating psychic tension and anxiety.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs



such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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This is a source of somatic symptoms of anxiety.

And this is a source of relief...

VALIUM® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

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Please see the preceding page for a summary of product information.

Artist's symbolic conception of a CNS reaction to excessive stress in the overanxious patient, resulting in somatic symptoms of the gastrointestinal and cardiovasc systems. Special photographic lighting techniques were applied to a model of the brain.

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Number 4

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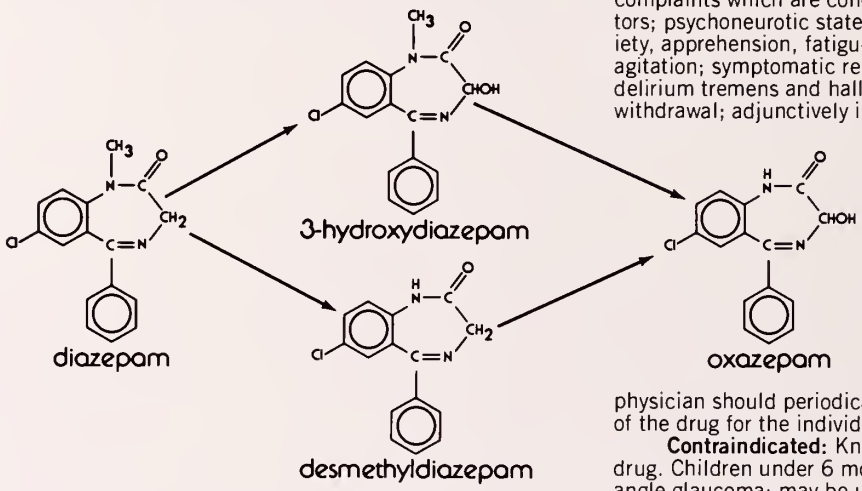
A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

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Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The Journal Of The Kentucky Medical Association

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MESSAGE FROM THE PRESIDENT

Out of Balance

SOCIALISM has swept the world in this century—in the extreme a utopian ideology with promises of equality for all, of equal distribution of wealth and benefits regardless of contribution, and of unlimited social programs financed by ever-growing deficits.

At the turn of the century free enterprise went too far—exploitation of labor and excessive accumulation of wealth in the hands of a few. Originally the unions fought a just cause—to obtain a fair share of labor's productivity. Concomitantly, a broad social consciousness developed to help the aged and those in need. The most extensive educational system the world has known was developed.

As might be expected, the pendulum often swings excessively. Today socialism has gone too far and is undermining the strength of our nation. Psychologically it offers security—cradle-to-the-grave care by "Big Daddy"—social security, free unlimited health care, food stamps, wages with no work or while on strike. It undermines the work ethic, the necessity to be productive, with confiscatory taxation and the total burden resting on an ever-narrowing base of workers. It is regressive to a childlike dependence on "Big Daddy". Economically, disaster is upon us as irresponsible deficit spending debouches our currency. The freedom and effectiveness of the marketplace has been replaced by government planned economy with its resulting chaos and unrelenting growth of bureaucratic regulation. But worst of all, socialism in its extreme is incompatible with individual freedom and liberty. It requires conformity—subjugation of the individual for the sake of the masses. It is dehumanizing—a homogeneous mass of people, all the same.

Is not the cry for freedom and opportunity for individuality basic to the human spirit? Where is our balance between social consciousness and fiscal responsibility, between pride in individual responsibility and productivity as opposed to regulation and dependency?

JOHN P. STEWART, M.D.
KMA PRESIDENT

POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

APRIL

12 "Interplay of X-ray and Endoscopy on Gastroenterology**," Louisville Area CME Consortium, St. Joseph Infirmary, Louisville

14-15 "Diabetes Control: Why and How*," University of Kentucky, Hyatt Regency, Lexington

18-25 "Controversies in Care: Obstetrics and Gynecology*," University of Kentucky College of Medicine, 30 hrs. credit, (Package Fee: $850), Maui, Hawaii

20-22 "High Risk Pregnancy**," University of Louisville, Executive West, Louisville

22 Cancer Update in the Park, "Gynecological Cancer," Kentucky Division, ACS, Kenlake State Resort Park

24-27 Postgraduate Course in Surgical Anatomy**, Health Sciences Center, Louisville

25-26 Establishing Yourself in Medical Practice Workshop, Ramada Inn-Bluegrass Convention Center, Louisville

26-27 Negotiations Seminar, co-sponsored by KMA and AMA, Louisville

28-May 1 Fourth Annual Postgraduate Course in Surgery, University of Louisville, Galt House, Louisville

MAY

4-5 "Medical and Behavioral Problems in Older Persons*," University of Kentucky College of Medicine, 12 hrs. credit, (Fee: $80), Hyatt Regency Lexington

17-19 "Surgical Diseases in Children: Radiologic Evaluation and Operative Correlation*," University of Kentucky College of Medicine, 15 hrs. credit, (Fee: $180, physicians; $90, residents), Hyatt Regency, Lexington

19-20 Spring meeting, Kentucky Surgical Society, Lake Cumberland State Park

19-20 Annual Spring Meeting, Kentucky Occupational Medical Association, Ramada Inn at Hurstbourne Lane, Louisville

20 Cancer Update in the Parks, "Childhood Cancer," Kentucky Division, ACS, General Butler State Resort Park

24-25 "Medical Management and Special Problems in the Treatment of Alcoholism," University of Louisville School of Medicine, Executive Inn, Louisville

24 "Diagnosis and Management of Arrythmias Associated with Myocardial Infarction**," Louisville Area CME Consortium, Health Sciences Center, Louisville

25-26 "Cardiology for the Practicing Pediatrician*," University of Kentucky College of Medicine, 12 hrs. credit (Fee: $85), Hyatt Regency, Lexington

27-28 "Advanced Cardiac Life Support, Instructors Course**," University of Louisville School of Medicine, 18 hrs. credit, (Fee: $125), Health Sciences Center, Louisville

30 "Dizziness**," Louisville Area CME Consortium, Health Sciences Center, Louisville

JUNE

2-3 Fiberoptic Bronchoscopy: A Workshop*, University of Kentucky College of Medicine, 13 hrs. credit (Fee: $250), Hyatt Regency, Lexington

2-3 Sixth Biennial Symposium on "Cancer in Women," Kentucky Obstetrical and Gynecological Society, Galt House, Louisville

3 Cancer Update in the Parks, "Management of Patient with Disseminated Cancer," Kentucky Division, ACS, Carter Caves State Resort Park

8-10 Wangensteen Symposium on Surgical Management of Visceral and Breast Cancer*, University of Kentucky College of Medicine, 15 hrs. credit (Fee: $150), Hyatt Regency, Lexington

14 "Update on Renal Transplants**," Louisville Area CME Consortium, Jewish Hospital, Louisville

24 Cancer Update in the Parks, "Skin Cancer," Kentucky Division, ACS, Jenny Wiley State Resort Park

28 "Estrogen and Progestational Steroids in the Female**," Louisville Area CME Consortium, Health Sciences Center, Louisville

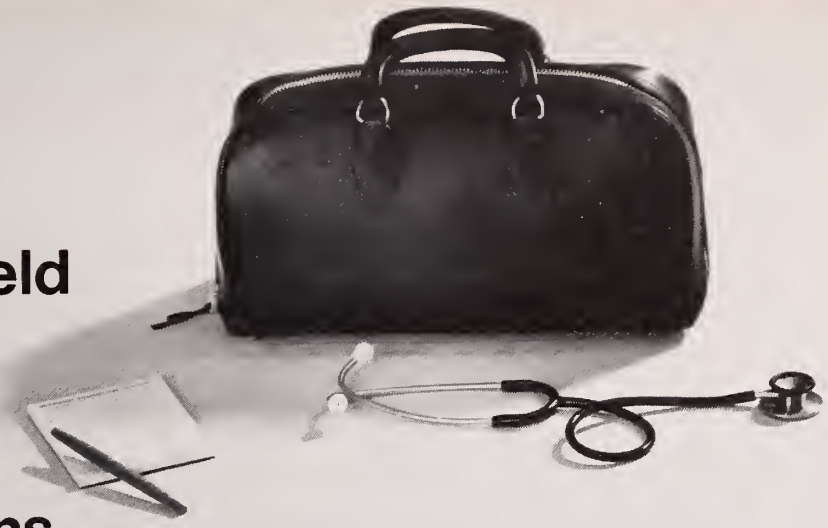
IN SURROUNDING STATES

APRIL

28-29 Third Annual Gynecological Oncology Course, Vanderbilt University School of Medicine, Nashville. Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, Tenn. 37212.

**For further information, contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, University of Kentucky College of Medicine, Lexington 40506*
***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

1977 Blue Shield Report To Physicians



Membership	**(as of December 31)** 1977	1976
Total Membership	1,400,606	1,366,752
Net Enrollment Gain or Loss (Members)	33,854	(947)
Percent of Net Increase or Decrease	2.48%	(.07%)
New Employee Groups Enrolled	1,759	1,336

Claims Experience Type of Contract	Number of Services Paid		Amount paid for Member Services	
	1977	1976	1977	1976
Indemnity	436,704	406,580	$16,857,354	$15,329,088
Usual, Customary and Reasonable	*470,128	417,369	24,679,976	21,710,968
Champus	*3,843	21,950	266,453	1,831,698
Extended Benefits, BCBS Medicare Supplement, Major Medical and F.E.P. Supplemental	210,782	159,713	18,612,806	11,535,017
Grand Totals	**1,121,457**	**1,005,612**	**$60,416,589**	**$50,406,771**

*64 Usual, Customary and Reasonable and Champus claims, representing less than .01% of claims submitted required Peer Review.

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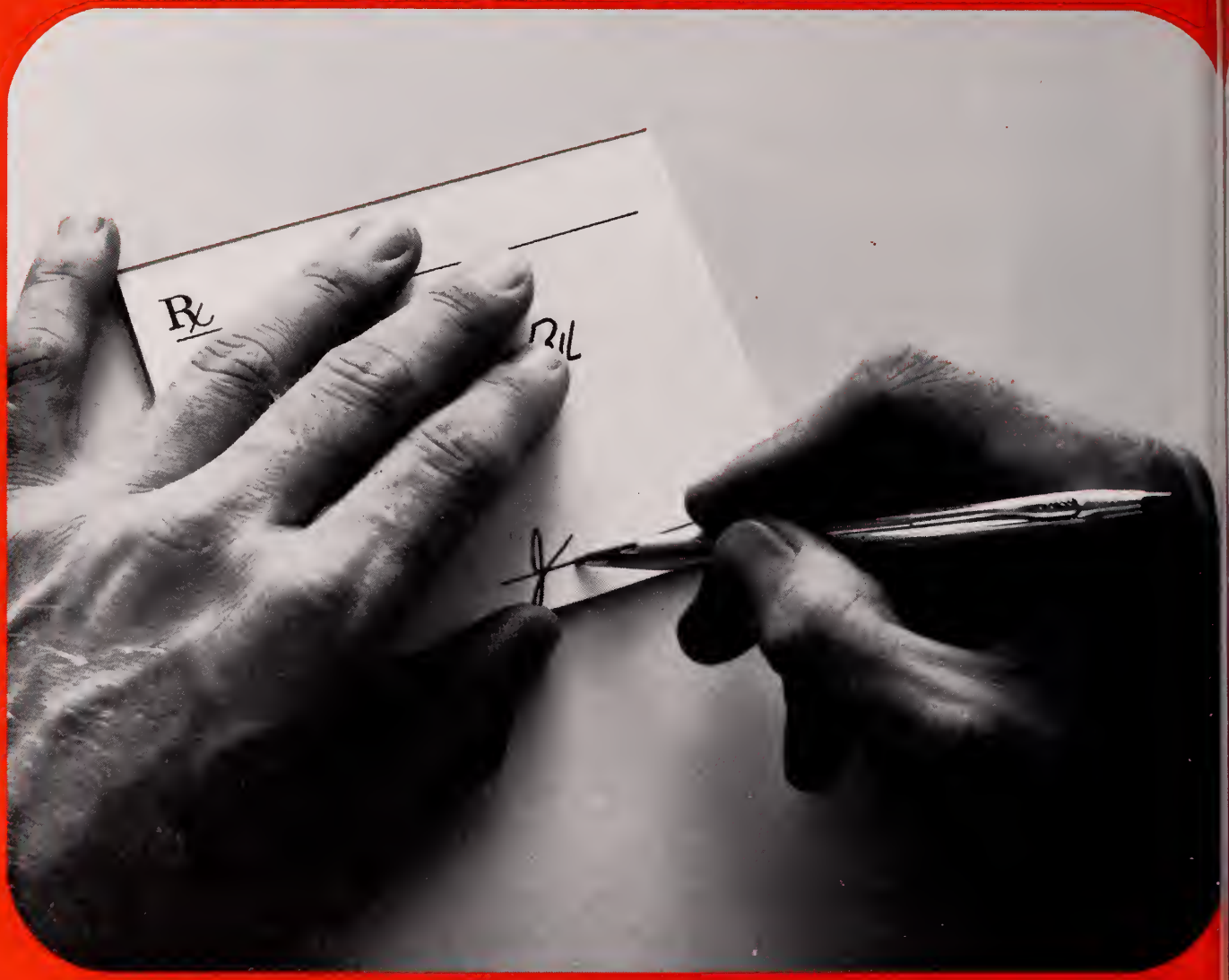

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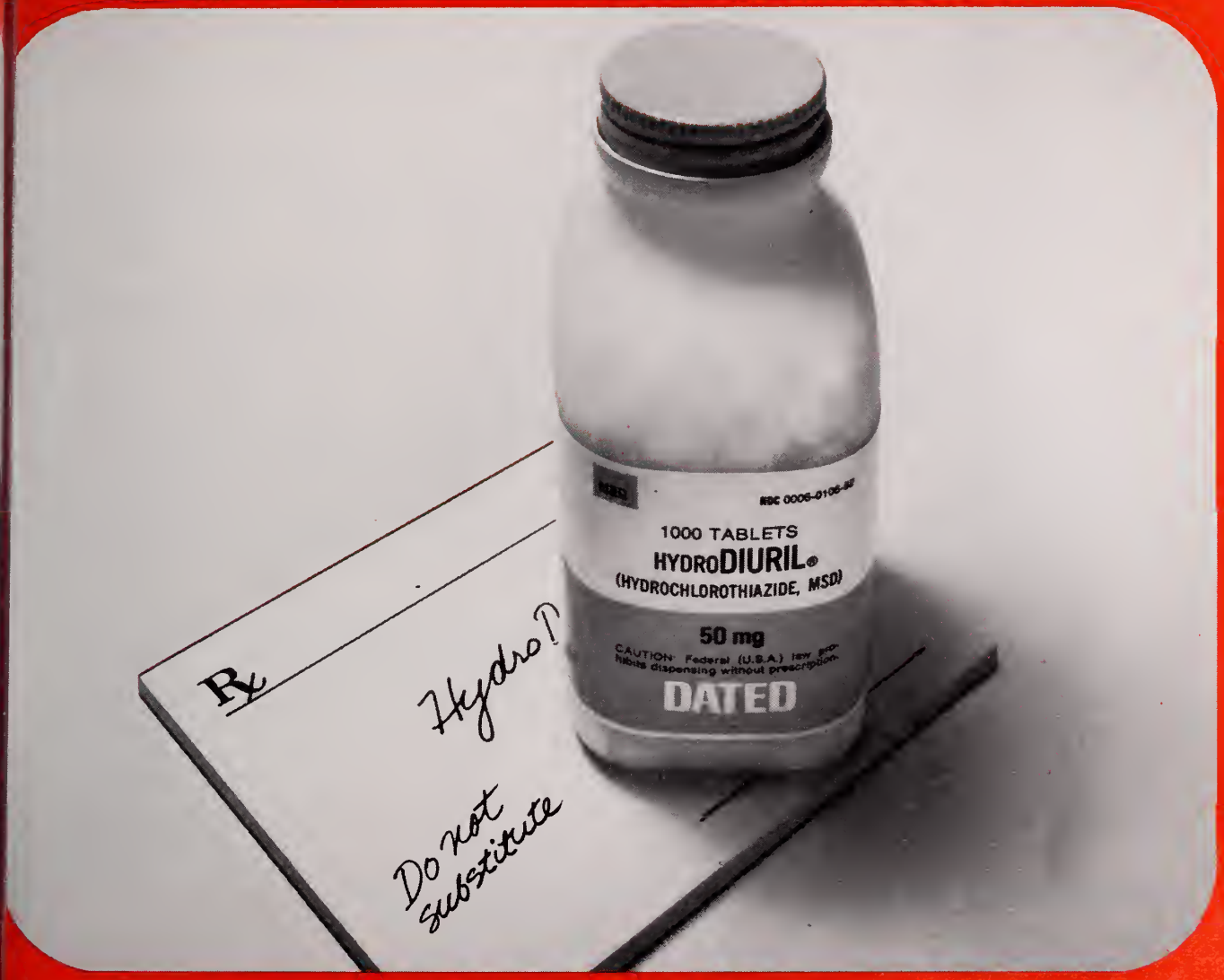
Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.
Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

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Letters to the Editor

The Letters To The Editor column is a means for the KMA physicians to express their opinions and viewpoints on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Letters To The Editor, Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Kentucky 40205. Communications should not exceed 250 words. The right to abstract or edit is reserved by the editors of *The Journal*. Names will be withheld upon request, but anonymous letters will not be accepted.

To The Editor:

The article by Short et al (76:75, 1978) entitled "Ultrasound Evaluation of the Gallbladder" is misleading. Conventional oral cholecystography (Graham-Cole Test) is an accurate and usually safe test for detecting primary gallbladder disease, and should not be replaced by Ultrasound. If on two successive attempts the gallbladder does not opacify, more than 95% of patients will have gallbladder disease. Please note "gallbladder disease." The OCG if properly performed is directed not only at detecting stones, but also at evaluating function. This information is extremely valuable to the clinician.

Ultrasound answers two questions about the gallbladder: 1) are stones present, and 2) what is the size of the gallbladder. Let us compare the two modalities. Stones can be detected on oral cholecystography in 90% of patients having stones. Ultrasound, in most labs, can also find stones in about 90% of patients with stones. Both examinations fail in 10% of patients for similar reasons: 1) gas and fecal material over the gallbladder, 2) patient is not properly positioned to detect layering stones, 3) size less than 2.0 mm., 4) the stone is of such density that it has poor reflective qualities for Ultrasound, or it may be the same density as the contrast agent in the gallbladder and be missed on X-ray. The size of the gallbladder can accurately be determined by cholecystography.

If the gallbladder does not opacify after two successive doses, 89% of the patients will have stones at surgery. Indeed, Ultrasound will confirm that 89% of patients with non-opacified gallbladders will have stones. This is redundant and expensive information. The surgeon will also find that an additional 7% of the non-opacified gallbladders will have cholecystitis and/or strictures. This same 7% will be considered normal by Ultrasound even though they have disease, and will now fall in the false-negative Ultrasound group. Surgeons, for understandable reasons, are interested in the false-positive cases, those cases considered to have disease, but at surgery are normal. Ultrasound and the OCG report about 5% in this group. There is no advantage for either examination, however I believe Ultrasound will improve in this area.

Ultrasonography, after two consecutive oral cholecystograms fail to opacify the gallbladder, is not necessary.

In our institution, Ultrasound examinations of the gallbladder are of secondary importance and are performed only in selected instances:

1. In patients who cannot tolerate or undergo oral cholecystography.
2. In patients with malabsorption or liver dysfunction.
3. In patients with acute right abdominal pain and the clinician indicates emergency information about the gallbladder is necessary.

The authors also condemn the "double dose" OCG as costly in time and radiation exposure. One need not practice cookbook radiology. A little forethought and imagination can be very rewarding in evaluating these patients. For instance, outpatients and certain inpatients (the elderly, those with severe physical debilities) should not undergo X-rays after the first dose. Give these patients two consecutive days of contrast agent, then X-ray. This eliminates one trip to the X-ray Department reducing patient, physician, and technician time to well below that of the Ultrasound examination. Two days OCG will be more accurate, less expensive, but unfortunately less impressive than Ultrasound.

Bibliography on Request

C. Dale Brown, M.D.
Department of Ultrasound
Lourdes Hospital
Paducah, Ky. 42001

To The Editor:

Thanks kindly for your mini-anatomy lesson on the brachial plexus by Dr. David Peck in the February 1978 *Journal of the Kentucky Medical Association.* I think all practitioners need that and hope you will continue it as a regular feature.

William E. McDaniel, M.D.
Suite 5—342 Waller Avenue
Lexington, KY 40504

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PHARMACEUTICAL DIVISION

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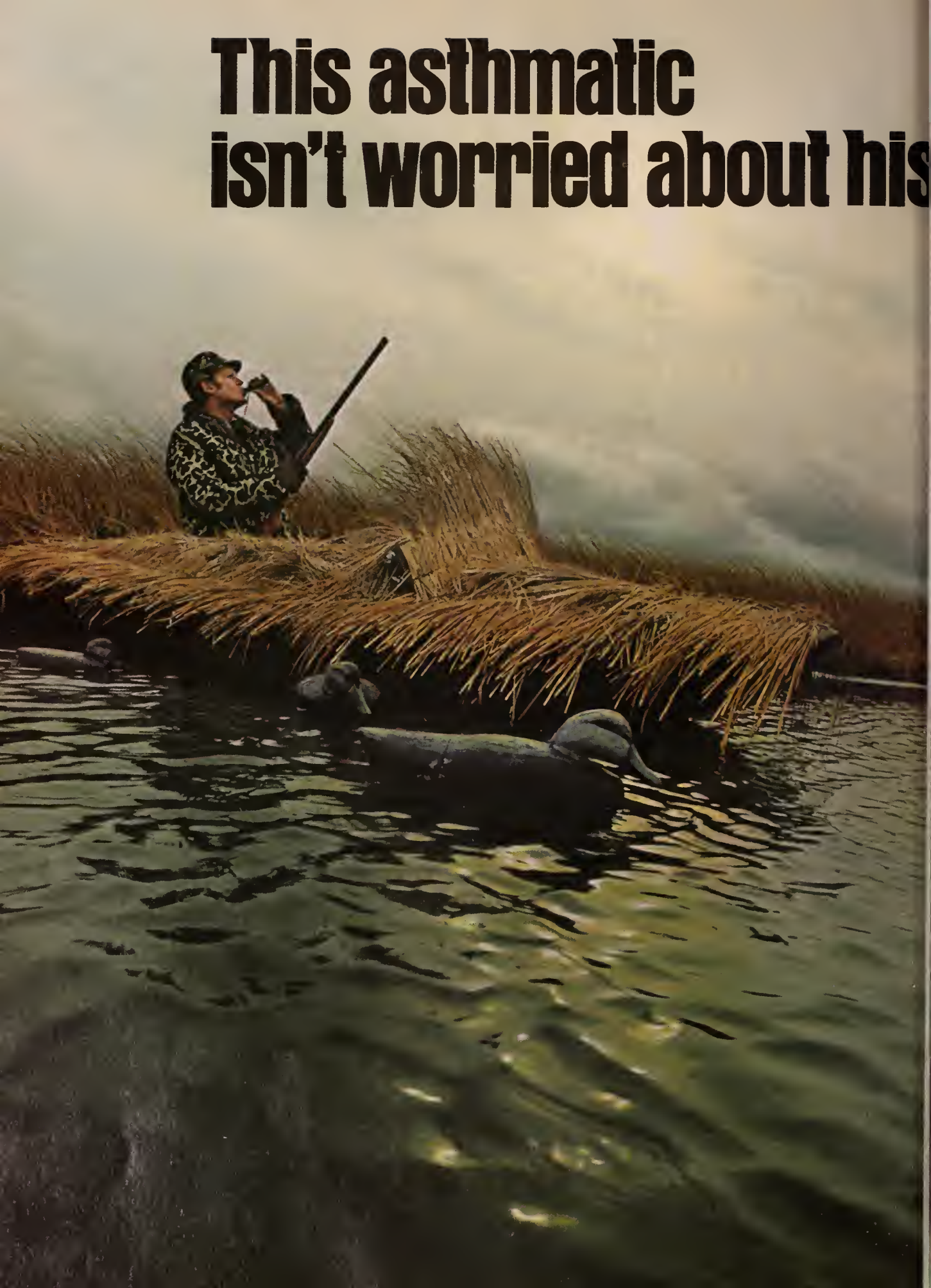

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For Brief Summary, please see the last page of this advertisement.

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Reference 1. Data on file, Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
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Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

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VOLUME 76 APRIL 1978 NUMBER 4

New Antihypertensive Drugs

Gurdarshan S. Thind, M.D.

Louisville, Kentucky

New antihypertensive drugs are being developed to selectively interrupt the renin-angiotensin-aldosterone feedback loop and the volume-sodium axis. Future emphasis of medical treatment will be primarily directed at correcting the biochemical abnormalities which trigger and accentuate the hypertensive disease.

THE availability of blood pressure lowering agents capable of affecting the beta-adrenergic receptors, renin-angiotensin-aldosterone system and sodium-volume axis, has been one of the most dramatic breakthroughs in developing ideal antihypertensive drug therapy. These drugs have been invaluable in enlarging our understanding of the physiological mechanisms involved in the regulation of normal blood pressure and pathophysiological abnormalities perpetuating the hypertensive process once established. Those agents blocking selectively the beta-adrenergic receptors have already proven their efficacy in the treatment of angina pectoris, ventricular and supraventricular arrhythmias, obstructive myocardiopathy and finally, arterial hypertension. The objective of this communication is to briefly discuss the clinical pharmacology and therapeutic uses of some of the new antihypertensive drugs which have either recently become available or hopefully will be approved for general clinical use in the United States in the near future. Finally, results of some of the clinical studies evaluating the efficacy and safety of new antihypertensive agents being carried out at the University of Louisville Health Sciences Center will be presented.

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Clinical Pharmacology and Therapeutic Indications

The potential development of new antihypertensive drugs falls into the following categories:

(A) New Beta-Adrenergic Blocking Drugs
(B) Other Anti-Renin Drugs
(C) New Diuretic Agents
(D) Direct Peripheral Vasodilators
(E) Angiotensin Antagonists and Converting Enzyme Inhibitors

New Beta-Adrenergic Blocking Drugs

The clinical pharmacology of beta-adrenergic blocking drugs has been recently summarized by Conolly and colleagues.[1] Although initially conceived of as a means of treating angina pectoris, these drugs have been found to offer much in the treatment of hypertension and several other quite different clinical situations. The major advantage of beta blockade in hypertension is the lack of

Table 1

PHARMACOLOGIC CHARACTERISTICS OF BETA-ADRENERGIC BLOCKING DRUGS IN HYPERTENSION TREATMENT

Drug	Beta Blocking Activity	Cardio-selectivity	Intrinsic Sympathomimetic Activity	Membrane Stabilizing Activity	Relative Potency as Beta-Blocker Compared to Propranolol = 1.0
Propranolol	+	−	−	+	1.0
Alprenolol	+	−	+	++	1.0
Oxprenolol	+	−	+	++	2.0
Prindolol	+	−	+	+	NA
Sotalol	+	−	−	−	0.1
Timolol	+	−	−	−	8.0
Practolol	+	+	+	−	0.5
Tolamolol	+	+	−	−	NA
Metoprolol	+	+	−	−	NA
Atenolol	+	+	−	−	NA
Acebutolol	+	+	+	+	NA
Pronethalol	+	−	+	++	0.1

NA = Data not available

postural hypotension after beta blockade and relative freedom from undesirable side effects. In the absence of obvious contraindications to beta blockade, these drugs are particularly useful from pathophysiological standpoint in the treatment of high renin and normal renin hypertension. As opposed to low renin hypertension, which is volume dependent, high and normal renin hypertension are predominantly maintained by vasoconstrictor mechanisms. Beta-adrenergic blockade produces a decrease in renin activity, decrease in stroke volume, sinus bradycardia and those beta blockers (propranolol and timolol) crossing blood-brain barrier also modulate the sympathetic discharge from the central nervous system.

(1) **TIMOLOL MALEATE.**

The beta-adrenergic receptor blocking activity and other pharmacological properties of the wide spectrum of these agents are summarized in Table 1.

Although a nonselective beta-receptor blocker, timolol maleate has several advantages over propranolol in the treatment of arterial hypertension. Unlike other beta-blockers, timolol maleate does not have significant intrinsic sympathomimetic activity, local anesthetic, or membrane stabilizing activities. The approximate ratio of negative ionotrophic to beta-receptor blocking effect is 7,000 for timolol versus 160 for propranolol in isolated cat papillary muscle preparation. The beta-adrenergic blocking effect of timolol is approximately 10 times greater than propranolol while the direct myocardial depressant effect is approximately five to six times less than that of propranolol. The oral absorption of timolol is significantly better than propranolol, and timolol is approximately 10 times greater than propranolol while the direct myocardial depressant effect is approximately five to six times less than that of propranolol. The oral absorption of timolol is significantly better than propranolol, and timolol is effective on a twice-daily regimen with a predictable antihypertensive response within one to two weeks of therapy. We have tested the efficacy of timolol maleate in the treatment of 30 patients with mild to moderate uncomplicated arterial hypertension and found it to significantly lower both diastolic and systolic blood pressures with an average daily dose of 32 ± 3 mg (SEM) at the end of one week of timolol maleate administration.[2] We have recently completed a study of administering timolol maleate in combination with other antihypertensive drugs in the treatment of severe arterial hypertension and found timolol to further lower the systolic and diastolic blood pressure by 21-26/15-17 mm Hg on a twice-daily dosage regimen with average total daily dose of 49 ± 4 (SEM) mg.[3]

Timolol was given to 22 non-azotemic, uncontrolled, essential hypertensive ambulatory patients in addition to maximally tolerated doses of two to four other blood pressure lowering drugs. None of the patients, however, concomitantly received guanethidine or other beta-adrenergic blocking drugs. Pre-timolol supine blood pressure and pulse (mean ± SEM) were $177 \pm 4/109 \pm 1$ mm Hg and 78 ± 2/min. Twenty of 22 patients completed the six-week timolol titration with daily maximal timolol dose of 49 ± 4 (SEM) mg. Fifteen patients have completed 12 and seven have completed 28 weeks of timolol therapy. There

has been no mortality or significant morbidity post-timolol except for asymptomatic mild sinus bradycardia in two patients. The post-timolol titration blood pressure and pulse were 150±5/92±3 and 67±2; 12 weeks post-timolol were 145±6/92±3 and 68±3; and 28 weeks post-timolol were 146±10/94±3 and 68±3/min; all highly significantly lower than pre-timolol values ($P<0.005 - <0.001$). Standing blood pressures and pulse were not different from the supine levels. Pill compliance with timolol was 96±1% and with other drugs was 91±2%. There were no significant changes in post-timolol serial hepatic, renal, and cardiac tests. Since the therapeutic response to timolol therapy is more predictable and the total daily dosage is relatively small, timolol may prove to be the preferred beta-adrenergic blocking drug to be used in combination with other antihypertensive medications in the medical management of severely hypertensive patients. The pertinent clinical data in one of the timolol-treated severely hypertensive patients is shown in Figures 1 and 2, and in Table 2. Timolol maleate has been submitted to FDA for approval in the treatment of hypertension and hopefully it will be available in the United States for general use.

(2) **OTHER BETA BLOCKERS** under investigation for treatment of hypertension in the United States among others include: pindolol (prindolol, visken, LB-46), oxyprenolol (trasicor), metoprolol, and atenolol. Pindolol has intrinsic sympathomimetic and membrane stabilizing activities in addition to noncardioselective beta-adrenergic blocking activity. The degree of sinus bradycardia may be less pronounced with pindolol therapy; however, results of more extensive clinical trials are awaited for evaluating its usefulness in arterial hypertension. The prominent intrinsic sympathomimetic activity of pindolol is probably responsible for the paradoxical loss of blood pressure control in a small proportion of patients where the dose is increased much above 40 mg daily. We have a clinical study underway at the University of Louisville Health Sciences Center evaluating the efficacy of thrice-daily dosage regiment of pindolol in mild to moderate uncomplicated hypertensive patients. The data available from our study so far is too preliminary to draw any conclusions. Metoprolol and atenolol are cardioselective beta-adrenergic blocking drugs and deserve further evaluation.

(3) **OTHER THERAPEUTIC USES OF BETA-BLOCKERS.**

Propranolol has been found useful in the treatment of tremors, and *timolol* has been found particularly useful in the treatment of wide-angle glaucoma due to its lack of effects on accommodation and relative prolonged lowering of intraocular pressure after local ocular instillation of timolol solution.

Other Anti-Renin Drugs

(1) **CATAPRES (Clonidine).**

Clonidine has been recommended as a useful and effective step-2 therapy in mild and moderate arterial hypertension as well as in severe hypertension as polypharmacy. Initial dose should be 0.1 mg tab bid with increments if necessary. The effects on the renin-aldosterone system after clonidine administration suggested that antihypertensive action of clonidine was in part mediated through suppression of renin in high and normal

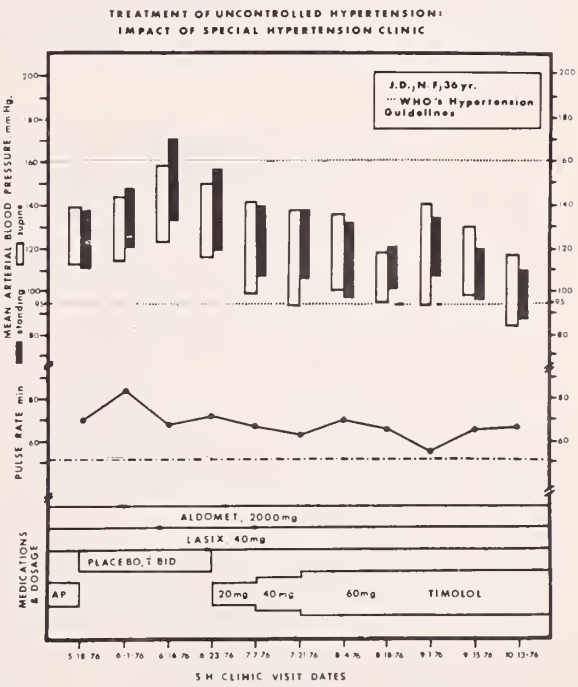

FIG. 1: Patient J.D., 36-year-old negro female with severe essential hypertension of 9 years. The 4 office visits from 5/18/76 thru 6/23/76 were used to evaluate compliance with previous antihypertensive medications. Both supine and standing BPs were higher on 6/18/76 due to the decreased compliance with aldomet and lasix in the preceding two weeks (Figure 2). The average supine BP was 151/118 mm Hg while receiving adequate dosage of aldomet and lasix. Timolol titration was begun on 6/23/76 and increased in increments of 20 mg to a maximum daily dose of 60 mg (in two divided doses) on 7/21/76. There was a gradual but very impressive decrease in the supine and standing BPs after timolol administration.

renin hypertension and another mechanism independent of renin mechanisms operated in all hypertensive patients including low-renin hypertensives. Changes in aldosterone in turn correlated significantly with changes in the renin activity after clonidine. The anti-renin effect of clonidine enhanced its antihypertensive effects not only by acutely ablating the renin-angiotensin pressor mechanisms, but also by inhibiting aldosterone production and thereby minimizing long-term reactive volume retention during treatment.[4]

The incidence of rebound hypertension was evaluated between 1966-1972. Of 1,865 patients abruptly withdrawn from catapres, 24 (1.3%) were reported to experience rebound hypertension. On further analysis, 11 of these (0.6%) exceeded pretreatment diastolic pressure levels. Seven of the remaining patients (0.4%) exceeded pretreatment systolic pressure levels. Thus it appears that the incidence of rebound hypertension after abrupt discontinuation of catapres is minimal and can be further minimized by gradual reduction of the dose of catapres over two to four days.

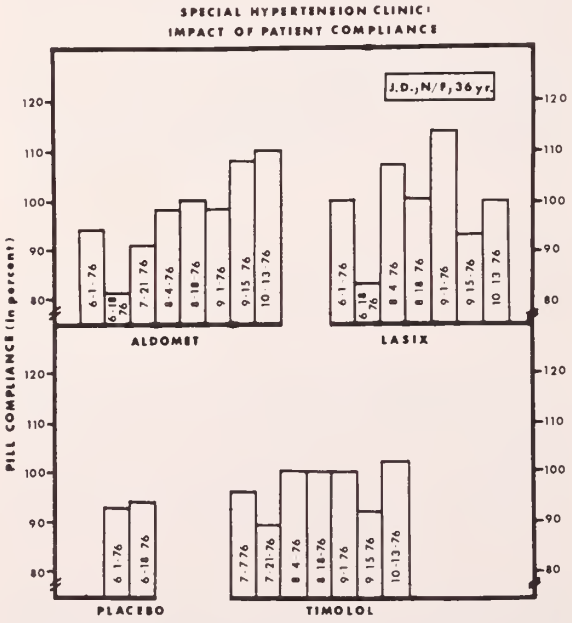

FIG. 2: Compliance with each individual medication was calculated on the basis of the number of pills actually ingested versus the expected total number of pills which should have been taken between office visits. Pill compliance was expressed in percent. It is noteworthy that when aldomet and lasix compliance was about 80% on 6/18/76, the BP was also higher (refer to Figure 1). Alterations in antihypertensive medications was only made if compliance with all medications was adequate; otherwise structured patient education techniques were used to correct the poor compliance problems.

New Diuretic Agents

(1) METOLAZONE (Zaroxolyn).

Metolazone, a new quinazoline diuretic, has significant antihypertensive properties. It has been effective in lowering the blood pressure in patients with mild to moderate essential hypertension. This drug, however, can produce many of the side effects of thiazides, including hypokalemia and hyperuricemia. The recommended dose of zaroxolyn for treatment of hypertension is 2.5-5 mg once a day, but appears to have no significant advantage over thiazides.[5]

(2) AMILORIDE AND MODURETIC.

Amiloride, a new potassium-conserving diuretic not yet available in the United States, has antihypertensive properties similar to thiazide diuretics but does not produce hypokalemia.[5] We are currently testing the efficacy of amiloride and a combination of amiloride with hydrochlorothiazide (Moduretic) in the treatment of uncomplicated mild to moderate arterial hypertension. It is probable that Moduretic may prove to be the diuretic of choice since potassium replacement frequently necessary with thiazide use will not be required with the use of Moduretic once-a-day regimen. Amiloride may on rare occasion produce hyperkalemia, especially when used in the presence of renal failure. Amiloride, however, has no discernable effect on serum glucose, uric acid, or chloride concentrations.[5] Moduretic appears to be the ideal antihypertensive diuretic since patient compliance should be better with it because concomitant oral potassium supplementation invariably needed with thiazide and loop diuretics will not be needed routinely.

Direct Vasodilator Agents

(1) PRAZOSIN HYDROCHLORIDE (Minipress).

Prazosin is an orally administered vasodilator that recently became available in the treatment of hypertension.[6] It causes less tachycardia than hydralazine, but may produce orthostatic hypotension, particularly after the first dose. The role of prazosin in therapy may be limited due to the risk of the first dose syncopal reaction, and it appears to be indicated primarily in patients who cannot tolerate hydralazine or sympathetic depressant drugs. Like other antihypertensive agents, prazosin should be given with a diuretic. In a double blind study recently reported, the antihypertensive effect of prazosin was less than

that of hydrochlorothiazide.[7] More recent studies appear to suggest that prazosin may be a useful adjunct in unloading the left ventricle in severe congestive heart failure patients.

(2) **MINOXODIL.**

This direct vasodilator agent is not available in the U.S. but has been found to be of value in treatment of severe arterial hypertension accompanied by marked renal insufficiency. Minoxodil is recommended in conjunction with other antihypertensive drugs in an effort to delay the necessity of dialysis in this small group of hypertensive patients. Minoxodil causes hypertrichosis and severe hirsutism and marked fluid retention accompanied by weight gain invariably in such patients. Because of substantial side effects, minoxodil should not be used as the initial drug in the treatment of hypertension. Like other vasodilator drugs (minoxodil when given in association with a diuretic and beta-adrenergic blocking drug) significant reduction in blood pressure can be accomplished in severe arterial hypertension with kidney failure.[8,9]

(3) **SODIUM NITROPRUSSIDE (Nipride).**

Nipride is the drug of choice in the treatment of hypertensive crisis that demands the immediate or at least very prompt reduction in arterial blood pressure to normotensive or mildly hypertensive levels. Nipride reduces both the afterload (peripheral resistance) and preload (venous return) to the heart and is the drug of choice in patients with hypertensive crisis with acute left ventricular failure. Nipride infusion is not accompanied by the undesirable reflex sympathetic stimulation seen frequently with the use of diazoxide.[10]

(4) **DIAZOXIDE (Hyperstat).**

Diazoxide only reduces the afterload and has no effect on the preload to the heart. Its intravenous use is invariably accompanied by reflex sympathetic overdischarge resulting in increased stroke volume, tachycardia, and possible exacerbation of coronary insufficiency. At the moment, diazoxide should be used only in situations where either Nipride is not available or when adequate help is not available to titrate Nipride infusion.

Table 2

LONG-TERM FOLLOWUP DATA OF PATIENT J.D. (FIGURE 1) IN SPECIAL HYPERTENSION PROGRAM AT THE U OF L SCHOOL OF MEDICINE

Office Visit	Supine* BP (mm Hg)	Standing* BP (mm Hg)	Pulse (per min)	Weight (lbs)	Antihypertensive Meds	Pill Compliance	Lab Evaluations† and Comments
Pre-TM**	151/118	159/124	81	191	Refer to Fig. 1	excellent	PRA-0.98 ng/ml/hr
11/10/76	131/98	121/101	65	198½	same as 10/13/76 Fig. 1)	excellent	PRA-0.4 (8/4/76), 1.45 (9/13/76) and 0.96 (11/8/76) ng/ml/hr
12/8/76	137/102	123/97	64	198½	unchanged	excellent	
1/5/77	137/105	129/107	62	199¾	Add Apresoline 10 mg qid	excellent	PRA of 0.07 ng/ml/hr
2/2/77	121/91	117/91	60	196½	same as 1/5/77	excellent	
3/3/77	116/86	108/90	64	196¾	unchanged	excellent	
4/6/77	124/87	112/91	60	192	unchanged	excellent	PRA-0.02 ng/ml/hr
5/4/77	95/65	87/63	62	193¾	Apresoline Discontinued	excellent	Patient completely asymptomatic but BP considered too low
6/2/77	131/96	123/93	60	194¼	same as 10/13/76	excellent	
7/5/77	128/98	135/110	56	196	unchanged	excellent	PRA 0.12 ng/ml/hr
8/1/77	149/110	143/117	72	197½	Add Apresoline 10 mg bid	excellent	Apresoline added to achieve better control
8/15/77	131/97	128/107	72	195¼	same as 8/1/77	excellent	
8/29/77	135/97	139/119	68	195½	↑ Apresoline to 25 mg bid	excellent	
9/26/77	125/88	105/95	68	198¾	same as 8/29/77	excellent	Felt weak on upright posture. Advised to change posture gradually.
10/24/77	121/89	107/85	64	196¼	unchanged	excellent	
11/21/77	121/89	112/84	64	199¾	unchanged	excellent	
12/19/77	115/83	111/90	64	200¼	unchanged	excellent	PRA 0.9 ng/ml/hr
1/19/78	123/84	118/81	72	198½	unchanged	excellent	Next office appointment 2/16/78

*Values are the average of three blood pressure readings.

**Data are the average of evaluation on 6/1/76, 6/18/76 and 6/23/76 while receiving Aldomet, 500 mg qid, Lasix, 40 mg and placebo, 1 tab bid. Creatinine clearance-126 ml/min, serum creatinine-0.7 mg%, SMA 20 nl, PRA-0.98 ng/ml/hr, EKG-nl, chest x-ray—mild cardiomegaly without congestive failure.

†Lab evaluation included CBC, urine analysis, SMS 20, 24 hour urinary electrolytes and total protein, lipid profile, creatinine clearance and ambulatory peripheral venous renin activity (PRA) while on sodium intake of 100-180 meq daily (normal PRA range of 2.7±0.89 ng/ml/hr). Unless indicated otherwise, repeat laboratory evaluations were unchanged on 11/10/76, 1/5/77, 4/6/77, 7/5/77, 12/19/77.

It may be used safely in patients with hypertensive encephalopathy but should be used with caution in other clinical situations constituting hypertensive crisis.[10]

Angiotensin Antagonists And Angiotensin Converting Enzyme Inhibitors

(1) SARALASIN (Sar[1]-Ala[8]-Angiotensin II).

Saralasin, an angiotensin II antagonist has a potential of becoming a sensitive diagnostic tool in determining the functional significance of angiotensin-dependent hypertension and might be a valuable screening test for the recognition of renal vascular hypertension. "Response" to a saralasin infusion, evidenced by a fall in blood pressure during infusion occurred in no patients with "low renin" hypertension and in only 20% of patients with normal renal arteriograms. In contrast, saralasin "RESPONSE" OCCURRED IN MORE THAN 80% OF PATIENTS WITH RENAL ARTERY STENOSIS AND LATERALIZING FUNCTIONAL STUDIES, AND IN 100% of CASES OF PROVEN RENOVASCULAR HYPERTENSION (cure or improvement of hypertension after operative treatment).[11]

(2) SQ20881 (Converting Enzyme Inhibitor).

SQ20881 inhibits the enzyme that converts angiotensin I, the nonpressor decapeptide, into angiotensin II, the most potent vasoconstrictor. Because this enzyme also inactivates bradykinin, a potent vasodilator, it has effects on both renin-angiotensin and kallikrein-bradykinin systems. Bolus injection of SQ20881 can also be used to identify the angiotensin-dependent hypertensive patients and may become a useful screening test for renovascular hypertension.[12]

Acknowledgements

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Carcinoma of the Gastric Fundus Within A Hiatus Hernia Case Report

Michael M. Fuenfer, M.D., Joseph G. Whelan, Jr., M.D., and Gerald D. Temes, M.D.

Louisville, Kentucky

This case represents a cancer of the stomach situated wholly above the diaphragm in a patient with a shortened esophagus and herniation of neoplastic gastric cardia into the thoracic cavity. At no time was a hiatus hernia demonstrated radiologically. This led to the preoperative impression of cancer of the distal one-third of the esophagus rather than adenocarcinoma of the stomach. Esophagoscopy and biopsy are necessary to complete the evaluation of these lesions.

THE occurrence of carcinoma of the gastric cardia in association with hiatal hernia is an uncommon finding. In this case upper gastrointestinal studies failed to demonstrate the presence of a sliding hiatus hernia. The appearance of a polypoid tumor mass in the distal esophagus would only rarely indicate primary esophageal neoplasm. These two x-ray findings, together with what appeared to be an area of normal esophageal mucosal above the esophagogastric junction, obscured the actual diagnosis which was not made until the time of operation.

Case Report

A 55-year-old white male with recently progressive, chronic gastric distress was referred for an upper gastrointestinal study (UGI). At the time of the initial study, the patient presented with dysphagia of two weeks duration accompanied by anterior chest pain when swallowing solid foods. These symptoms were not manifest with liquids. He had no history of nausea or vomiting, melena or weight loss. He had had chronic epigastric distress for the past 25 years, relieved somewhat by antispasmotics. A UGI study in 1959 reported duodenitis and gastritis.

A strong family history of cancer was revealed. The patient's mother died at age 40 of hepatoma, one brother died at age 51 of esophageal cancer, and another brother died at ago 50 of a brain tumor.

The patient has smoked one to three packages of cigarettes per day since he was a teenager. His alcoholic intake approximates four beers per day for the past 24 years. Past surgical history includes an appendectomy in 1957, repair of a right inguinal hernia in 1961, and excision of a spermatocele in 1968. There were no previous cardiovascular or pulmonary abnormalities.

Physical examination revealed a slightly obese middle-aged man in no acute distress. Laboratory studies were normal and there were no unusual physical findings.

The radiographic studies demonstrated a polypoid circumferential lesion in the distal one-third of the esophagus, approximately 5.5 cm in length. (Figure 1). There appeared to be an area free of tumor distal to the lesion. A tentative diagnosis of a malignant lesion involving the distal esophagus was made. Esophagoscopy disclosed markedly edematous and reddened mucosa with a soft polypoid mass extending into the lumen of the esophagus at 32 cm. Bronchoscopy revealed no evidence of tumor invasion of the tracheobronchial tree. The biopsy revealed adenocarcinoma.

With a preoperative diagnosis of adenocarcinoma of the lower third of the esophagus, exploration of both the abdomen and the chest were undertaken. The abdomen was normal except for an enlarged hiatus. Exploration of the chest revealed a tumor mass in the "distal esophagus", behind the heart. There was no other evidence of tumor within the chest or

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Received at KMA: 11-30-77.

FIG. 1 Preoperative esophagram demonstrating the presence of a mass lesion involving the distal one-third of the esophagus. This polypoid area is ulcerated posteriorly and there appears to be an area of normal esophageal mucosa distal to the lesion. At surgery this was found to actually represent gastric mucosa.

mediastinum. Lymph nodes did not appear to be involved. Resection of the distal one-third of the esophagus and proximal one-half of the stomach was performed followed by esophagogastric anastomosis. Gross and microscopic examination of the resected specimen demonstrated an infiltrating adenocarcinoma arising in the gastric mucosa near the esophagogastric junction and extending through the muscularis mucosa into, but not through, the muscular wall, to the gastroesophageal junction (Figure 2). The esophagus was not involved.

The patient's postoperative course was satisfactory. Twelve months postoperatively the patient is free of recurrent disease, with no complaints of dysphagia to liquids or solid foods. Follow-up esophagrams demonstrate complete patency of the anastomotic site.

Discussion

Radiographic studies in this patient demonstrated the presence of a neoplasm with partial obstruction in the distal esophagus. There appeared to be a segment of normal esophagus below the lesion. This actually represented gastric mucosa in the herniated portion of stomach. The hiatus hernia was obscured radiographically. When the histologic type of the tumor mass was identified as adenocarcinoma by biopsy the origin of the lesion was unclear.

A polypoid esophageal lesion on x-ray could be indicative of esophageal varices, moniliasis (generally seen in immunosuppressed patients), lymphoma, and tertiary contractions.[1] All of these possible diagnoses were excluded in our case because they are usually diffuse and involve a long segment of the esophagus. Other possibilities to be considered are a foreign body, mesenchymal tumors such as leiomyoma, lipoma, neurofibroma, and their malignant counterparts, as well as uncommon mucosal defects such as abscess, enteric cyst, melanoma, and a metastatic neoplasm.[2] Biopsy and endoscopy are necessary

FIG. 2 Photographs of resected portions of distal esophagus and proximal stomach show the tumor to be gastric in origin within a hiatus hernia (solid arrows). Histologic examination of the esophagus above the esophagogastric junction demonstrated this area to be free of malignant cells (open arrows).

to differentiate these lesions. The ulcerative radiologic appearance of the distal esophagus may be due to peptic ulceration in columnar metaplasia in a Barrett's esophagus.[3,4] However, in this condition, the margins of the ulcer usually are nodular.

In a recent review, Mayer et al[5] found 11 cases of carcinoma of the gastric cardia appearing in 1,476 patients with hiatal hernia. Eight of these were men whose ages ranged from 48 to 81 years with the average age being 64 years. Most had accompanying reflux for longer than five years. The presenting symptom in all cases was dysphagia. The majority had accompanying gastric intestinal hemorrhage, exacerbation of chronic heartburn and weight loss. The patient in this report at no time had a hiatal hernia demonstrable radiologically. Other unusual features were his lack of melena, anemia, and weight loss. The only significant complaint that prompted current esophageal studies was dysphagia.

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Brown Recluse Spider Bites: An Update

Philip C. Anderson, M.D.

Columbia, Missouri

Brown recluse spider bites are usually benign, only a few are large and necrotic, and very rarely does systemic hemolysis occur. Conservative treatment is proper. For severe hemolysis, early treatment with steroids and peritoneal dialysis is suggested. Current research is reviewed.

FORTY years have passed since Macchiavello's discovery, in Chile, that some necrotic ulcerations of the skin due to spider bites were caused by the venom of *Loxosceles laeta,*[1] and 20 years since Atkins proved the same skin-necrotizing properties for the venom of the North American brown recluse spider, *Loxosceles reclusa.*[2] The bite of this spider may cause two distinquishable medical disorders; first, a cutaneous injury which can vary from a small papule to a hugh necrotic ulcer, and, secondly, an intravascular hemolysis with disturbances of blood coagulation.[3] Fortunately, very few envenomations are severe. The milder brown recluse spider bites, because they do not become necrotic, are not even diagnosed.[4] However numerous these trivial bites may be, the medical literature remains preoccupied with the rare, severe envenomations. The practitioner must be aware that nearly all brown recluse spider bites have a benign course and conservative management is justified. A brief review of two decades of the study of loxoscelism shows progress both in practical medical management and, more recently, in basic understanding of the pathophysiology.

Physicians generally became more aware of loxoscelism about the mid-1960's because this common house spider was being carried from its native area to every state in the nation in furniture vans. Reviews of this little-known disease by Dillaha[5] and Pitts[6] improved medical reporting, nationally. Experience with the severe hemolytic form had been accumulating, as reviewed by Nance.[7] At the same time, thorough studies of the life cycle and habits of this spider were completed, aimed particularly at eradicating the spider from the home.[7,8] This effort has not succeeded. Eradication of the spider even from a small home is almost impossible especially under current rulings by the U.S. Environmental Protection Agency limiting the uses of pesticides.

In 1973 Millikan[10] developed a landmark diagnostic test, an in vitro lymphocyte transformation, which was sensitive and specific. It was then possible to verify the diagnosis in cases where the spider was not captured. More importantly, it was possible to recognize that trivial brown recluse spider bites were very common[11] and may be important events in the production of immune defenses. The discovery of the trivial bite and the resulting immunity may explain the rarity of skin ulcerations in the numerous households where these spiders flourish. We understood better why the severe hemolytic form occurred principally in children, who had the least immune defenses.

Eventually, the therapeutics of loxoscelism should be founded in an understanding of actions of the venom on tissues. The isolation of the skin-necrotizing fraction (SNF) has proven to be a difficult task as SNF comprises only 0.02% crude venom. Recent identification by Campbell shows SNF contains sphingomyelinase,[12] and studies are under way to neutralize the venom or protect the cells in more effective ways. The red blood cells are destroyed directly by the venom without using a complement or the energy systems of the cells. Calcium ions are necessary to the action of the venom. Compared to other spider venoms, the venom of *Loxosceles reclusa* is an unusually complex material.

Diagnosis and Treatment

The key observation in the presumptive diagnosis of loxoscelism is the blue-gray macular area of skin, sharply demarcated, often with a configurate border, which is sinking slightly and becoming increasingly painful to the touch. This entire process may take from 2 to 12 hours,

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usually about 6 hours, to manifest itself. Persons still well at 24 hours are almost surely safe. It is useful to measure the necrotic area accurately. Ecchymoses around the necrotic area should not be included in this measurement. We find that bites measuring less than 4 cm across at 12 hours are almost always uncomplicated and that the larger bites are more likely to induce hemolysis and require prolonged treatment.

Hemolysis can be detected either by testing of the urine or by measurement of free hemoglobin in the serum. Hemolysis is a danger sign to the physician to keep the patient under close observation. Hemolysis usually develops rapidly, in a few hours reducing the hematocrit from 40 to 10%. Another sign of impending complications, in our opinion, is the extension of the bite into a thick fat pad, such as thigh or buttock. Bites in lean skin and muscle are less threatening.

Small bites, about 4 cm or smaller, may require no treatment except control of pain, proper protection from tetanus, and reassurance. Proper observation may require several visits during most of a day. Larger bites are treated in our clinic with corticosteroids for three to five days, beginning with approximately 100 mg of prednisone daily. Clinical experience suggests that pain and cutaneous reaction may be reduced somewhat but the actual size of the final ulcer is unaffected by this treatment. The purpose of using steroids is to prevent hemolysis and minimize abnormal clotting. Again, final proof of these impressions awaits additional studies with purified venom. To date, in our experience, no patient who was treated early with high dose steroids has progressed to hemolysis.

If severe hemolysis occurs, anuria may follow and disseminated intravascular coagulation may become a severe complication. A few patients with severe coagulation disorders have benefited from heparin.[13] The anuria has been managed by peritoneal dialysis with impressive success.[14] Neither venom nor hemoglobin is removed by dialysis but stabilization of body pH, glucose levels, and total free fluids may account for some improvement, added to the relief from uremic poisoning. At present, we favor the early use of dialysis, within 72 hours, as soon as the indications are clear. Management of the cutaneous problem is deferred until the systemic disease is well-controlled.

We do not employ early or preventive surgery for the treatment of loxoscelism since almost all of the bites remain small, arrest their spread, and heal well. It cannot be predicted which of these bites are those very rare ones that will progress to large ulcers or induce systemic disease. The routine early excision of all suspected spider bites seems an instance of enormously expensive, potentially disabling overtreatment. Further evaluations of treatment should report all and only proven *Loxosceles reclusa* bites, as some other spider bites may closely mimic these if considered in the first few hours of their development. Cutaneous loxoscelism may show severely retarded healing and reparative surgery may be a great benefit, employed usually after approximately four to six weeks of evaluation.

A particularly valuable source of information regarding loxoscelism has come from physicians who were bitten themselves. Communications are invited by mail or phone concerning the bite of this most venomous North American house spider.

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Final classification of the less-than-effective indications requires further investigation.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

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As with all anticholinergics, inhibition of lactation may occur.

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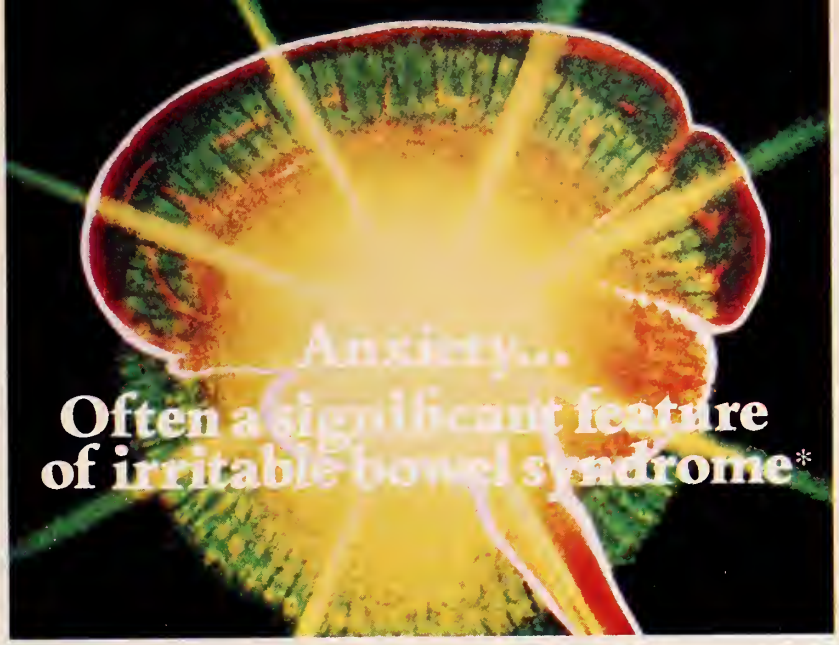

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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> **Warning**
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

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The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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EDITORIAL

An Historical—Yet Timely—Message

We often hear criticism of the press, some justified and other less so. Occasionally legitimate criticism arises from a knowledgeable source which is worthy of attention:

"It is a free press—a press that is more than free—a press which is licensed to say any infamous thing it chooses about a private or a public man, or advocate any outrageous doctrine it pleases. It is tied in no way. The public opinion which should hold it in bounds it has itself degraded to its own level. There are laws to protect the freedom of the presses' speech, but none that are worth anything to protect the people from the press. A libel suit simply brings the plaintiff before a vast newspaper court to be tried before the law tries him, and reviled and ridiculed without mercy. The touchy Charles Reade can sue English newspapers and get verdicts; he would soon change his tactics here; the papers (backed by a public well taught by themselves) would soon teach him that it is better to suffer any amount of misrepresentation than to go into our courts with a libel suit and make himself the laughing stock of the community . . .

"The difference between the tone and conduct of newspapers today and those of 30 or 40 years ago is very noteworthy and very sad—I mean the average newspaper (for they had bad ones then, too). In those days the average newspaper was the champion of right and morals, and it dealt conscientiously in the truth. It is not the case now . . . It has become a sarcastic proverb that a thing must be true if you saw it in the newspaper. That is the opinion intelligent people have of that lying vehicle in a nutshell. But the trouble is that the stupid people—who constitute the grand overwhelming majority of this and all other nations—do believe and are molded and convinced by what they get out of the newspaper, and there is where the harm lies.

"Among us, the newspaper is a tremendous burden. It can make or mar any man's reputation. It has a perfect freedom to call the best man in the land a fraud and a thief, and he is destroyed beyond help. Whether Mr. Colfax is a liar or not can never be ascertained now—but he will rank as one until the day of his death—for the newspapers have so doomed him . . .

"Nearly all newspapers foster Rozenweigs and kindred criminals and send victims to them by opening their columns to their advertisements. You all know that . . .

"The newspaper that obstructs the law on a trivial pretext, for money's sake, is a dangerous enemy to the public weal.

"That awful power, the public opinion of the nation, is created in America by a horde of ignorant, self complacent simpletons who fail at ditching and shoemaking and take up in journalism on their way to the poor house. I am personally acquainted with hundreds of journalists, and the opinion of the majority of them would not be worth tuppence in private, but when they speak in print it is the newspaper that is talking (the pygmy scribe is not visible) and then their utterances shake the community like the thunders of prophecy . . .

"The license of the press has scorched every individual of us in our time, and I make no doubt. Poor Stanley was a very god, in England, his praises in every man's mouth. But nobody said anything about his lectures—they were charitably quiet on that **head,** and were content to praise his higher virtues. But our papers tore the poor creature limb from limb and scattered the fragments from Maine to California—merely because he couldn't lecture well. His prodigious achievement in Africa goes for naught—the man is pulled down and utterly destroyed—but still the persecution follows him relentlessly from city to city and from village to village as if he had committed some bloody and detestable crime . . . In a town in Michigan I declined to dine with an editor who was drunk, and he said, in his paper,

that my lecture was profane, indecent, and calculated to encourage intemperance. And yet that man never heard it. It might have reformed him if he had.

"A Detroit paper once said that I was in a constant habit of beating my wife and that I kept this recreation up, although I had crippled her for life and she was no longer able to keep out of my way when I came home in my usual frantic frame of mind. Now scarcely the half of that was true. Perhaps I ought to have sued that man for libel—but I knew better. All the papers in America—with a few creditable exceptions—would have found out then, to their satisfaction, that I was a wife beater, and they would have given it a pretty general airing, too . . .

"But I will not continue these remarks. I had a sort of vague general idea that there is too much liberty of the press in this country, and that through the absence of all wholesome restraint the newspaper has become in a large degree a national curse, and will probably damn the republic yet . . ."

Samuel Langhorne Clemons,
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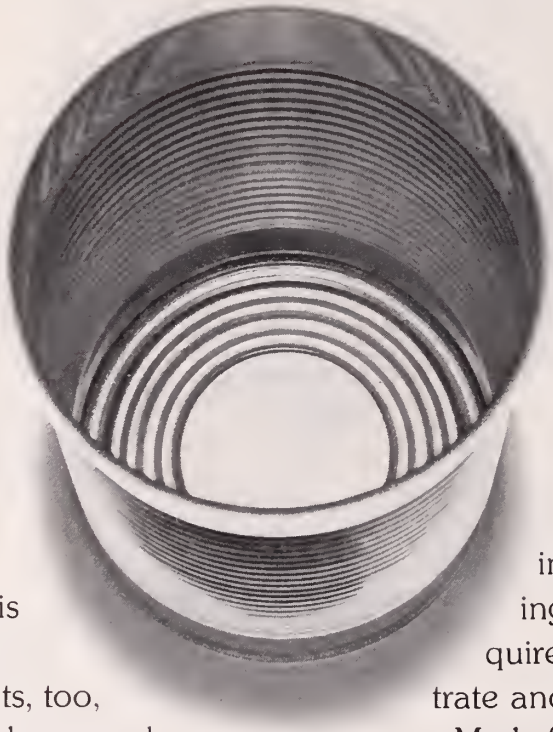

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MATERNAL MORTALITY

From the Files of the KMA Maternal Mortality Study Committee

—Edited by John W. Greene, Jr., M.D.

A 28-year-old married white female, gravida 3, para 2, was admitted to a 199-bed hospital with irregular contractions. Past history revealed two normal deliveries, the last of which was 10 years ago and the infant weighted 7 lbs 3 oz. Her current prenatal course had been unremarkable. Blood pressure and weight gain were normal. On admission near midnight, examination showed a term pregnancy. Her blood pressure was 100/50; fetal heart rate 144. The cervix was closed and the membranes intact. She was observed throughout the night with irregular contractions. Her only complaint was of backache.

At 7 a.m. her contractions became regular and the cervix dilated to 3 cm. Blood pressure, pulse and fetal heart were stable. At 8:15 a.m. the membranes were artificially ruptured. Much meconium was noted in the amniotic fluid. Blood was typed and cross-matched because of a possible cesarean section. Vital signs remained stable. At 8:30 a.m. the patient was given Demerol 75 mg and Phenergan 24 mg I.M. At 9:30 a.m. contractions were every 1-1/2 minutes and lasting 45 seconds.

At 10:30 a.m. the cervix was 4 cm dilated, fetal heart rate 140, and the patient again complained of backache. At 11:30 a.m. the patient passed more meconium stained amniotic fluid. Blood pressure and other vital signs were stable.

At 12:10 p.m. she complained of severe interscapular pain. She was turned on her right side and she became cyanotic. Her physician was called. The patient developed a sinus tachycardia and the fetal heart was absent. She remained alert. The cervix was 8 cm and the vertex at +3 station. The family was informed of the patient's serious condition. The patient was given 8 mg of morphine I.M. and oxygen.

Cardiorespiratory arrest occurred almost shortly after 12:10 p.m. She was intubated and external cardiac massage was performed. The infant was delivered by outlet forceps over a small midline episiotomy. It weighed 8 lbs 7 oz and was in poor condition with an apgar of one. The infant was cared for by a second physician.

The placenta was spontaneously expressed. She was given IV Pitocin and Methergin. She was also treated with antihypotensives, and IV bicarbonate. Severe bleeding came from the uterus which failed to contract despite bimanual massage and IV Pitocin. Three blood transfusions were given. The patient remained in shock without audible blood pressure, pulse, or respirations. An emergency supracervical hysterectomy was done while the patient was being resuscitated and transfused. The patient didn't respond and expired at 1:45 p.m. The baby expired in three days.

Comment

The Committee classified this as an obstetrical nonpreventable death. Profound or sudden shock out of proportion to blood loss occurring unexpectedly in a woman in labor or who has just delivered is nearly "sine quo non" evidence of severe amniotic fluid embolism. This patient demonstrated this classically. The patient is usually a multipara, with ruptured membranes, a large fetus and in active or hard labor although it is not always tumultuous. The shock is frequently associated with a chill followed by dyspnea, cyanosis, and restlessness. Frequently, the patient's behavior immediately before the shock episode is bizarre and incoherent. Pulmonary edema quickly develops. Pulmonary edema alone in the absence of pre-existing heart disease is evidence of pulmonary embolism.

The presence of much meconium in the amniotic fluid alerted her physician for possible fetal distress and she was fortuitously typed and cross-matched. This blood was available during her postpartum hemorrhage. Generally, the more particulate matter in amniotic fluid, the more serious the insult if embolism occurs. The frequent association of the dead fetus syndrome with Amniotic Fluid Embolism may be due to the weakened membranes of the amniotic sac of the dead fetus. Nearly all patients with amniotic fluid embolism are at term or overdue. Again, this patient demonstrated that the occurrence of uterine atony in cases of amniotic fluid embolism is extremely resistant to treatment.

The mortality rate of amniotic fluid embolism is greater than 80%; 25% die within the first hour. Prompt correct treatment is mandatory if the patient is to survive.

Treatment

1. The cyanosis should be treated promptly with IPPB with high O_2 mixture and Isuprel (1-400 dilution). This reduces the cyanosis and the pulmonary artery spasm. Isuprel could also be titrated in a mixture of 1 ampule of Isuprel to 500 cc D_5W. Hydrocortisone 500 to 1000 mg IV stat as often as necessary can be given.

2. If pulmonary edema develops, the patient should be placed in a semi-upright position, placed positive pressure machine, and given O_2. Lasix 40 mg is given IV.

3. If the patient becomes hypotensive secondary to the amniotic fluid embolism, Dopamine (one ampule in 250-500 cc of D_5W) can be titrated to increase blood pressure to a systolic pressure of 90-100 mm Hg. Urine output should be maintained.

4. The second significant cause of death is hemorrhage. Diagnosis and correction of the blood loss is mandatory. Monitoring of patients with central venous pressure is helpful. Fresh or frozen plasma is best to control the bleeding problem. Fibrinogin should be available as a last resort. The nurse in charge should know where it is to be found (blood bank, central supply, etc.).

5. If bleeding persists and the agents to control the bleeding are not effective, operative procedure may be instituted.

6. An emergency kit should be available in all obstetrical units. It should contain multiple items—Lasix, hydrocortisone, Dopamine, Morphine, Isuprel, cryoprecipitate.

Summary

1. The rarity and unpredictability of amniotic fluid embolism makes it difficult to "be prepared" for the catastrophe. However, the 80% mortality makes it mandatory that every obstetrical unit have an emergency kit with guides to follow.

2. Judicious use of pitocin is always advisable. However, more caution should be used in a uterus with a large baby, or large amounts of amniotic fluid, a dead fetus, infected uterus, or possible abruptio placenta.

3. Tumultuous uterine contractions should alert the attending person for this possibility.

4. Amniotomy should be used either in a vaginal delivery or just prior to delivery in a c-section to prevent the amniotic fluid from being forced into the uterine sinuses during a contraction.

5. A second physician who has experience in cardiopulmonary support should be available.

★

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ASSOCIATIONAL NEWS

KMA TO FORM INSURANCE COMPANY

The Kentucky Medical Association will form its own Professional Liability Insurance Company.

The KMA Board of Trustees has spent considerable time in recent months studying the concept of forming its own Professional Liability Insurance Company and looking at other alternatives concerning Professional Liability Insurance in Kentucky. The Board of Trustees' continuing study of this matter was done at the request of the House of Delegates during its meeting in September, 1977. The action of the Board reaffirmed the Board's intention to make it possible for Kentucky physicians to control their own destiny.

Members of KMA's Board of Trustees met in a special session, March 8-9, to discuss the formation of the Kentucky Medical Insurance Agency.

Many reasons were listed at the Board meeting held March 8-9 for the action taken which came on a unanimous vote.

KMA's first step toward the formation of its insurance company will take place with the immediate formation of a Kentucky Medical Insurance Agency which will be headquartered in the KMA Headquarters Building. The Agency will be in a position within a short time to begin selling both primary and excess Professional Liability Insurance policies.

The Physicians' Insurance Company of Ohio (PICO) has been working with the Kentucky Medical Association and will assist KMA in the formation of its company. Plans call for the KMA Agency to sell PICO policies to Kentucky physicians. While these are policies from the Ohio-based doctor-owned company, all policies sold in Kentucky will be based solely on Kentucky rates. As soon as sufficient capital has been accumulated, the Kentucky physician-owned company will commence its own operation and take over PICO policies in cooperation with PICO.

The purpose of PICO coming into Kentucky is to assist KMA in forming its own company in the easiest possible way, to provide reinsurance and managerial services if needed, and further, PICO will be a financial investment in the Kentucky Medical Insurance Company.

Further information will be forthcoming through direct mailings, the "Communicator," the *Journal,* and at meetings across the state.

Emergency Seminar To Offer CME Credit, CPR Sessions

The Eighth Annual Emergency Medical Care Seminar, scheduled for June 7-9, will be held for the first time in conjunction with the Third Emergency Medical Services Conference of the Commonwealth of Kentucky.

This year's Seminar, to be held at the Executive West in Louisville, is dedicated to the memory of William J. Carey, M.D., a longtime member of the Emergency Medical Care Committee of KMA, who died unexpectedly early this year.

The program will feature numerous scientific presentations by physicians, nurses, dentists, lay persons, etc. dealing with the themes, "Dilemmas" and "The High Risk Newborn." Specialty interest group meetings, as well as cardiopulmonary resuscitation workshops, will be held on Wednesday and Thursday afternoons. The administrative session, sponsored by the Commonwealth of Kentucky, is set for June 8 and 9.

Continuing education credit has been applied for from the AMA, Kentucky Dental Association, Kentucky Chapter of the American College of Emergency Physicians, Emergency Department Nurses Association, National Registry of Emergency Medical Technicians, and Kentucky State Association of Licensed Practical Nurses.

Over 500 health professionals are expected to attend this year's meeting, which is the only one of its nature presented in Kentucky. For more information on registration, which is $15 per day, contact the KMA Headquarters Office.

KMA Staff Changes Announced

Robert G. Cox, Executive Vice President of KMA, announced a change in title of William T. Applegate, from Assistant Executive Vice President to Executive Director, effective April 1.

On that same date, Robert E. Klinglesmith, Director, Continuing Education Activities, was promoted to the

newly created position of Assistant Executive Director.

These staff changes are designed to keep pace with a growing KMA staff and increasing activities and programs. The formation of a KMA-sponsored liability insurance company will entail a great deal of involvement of the KMA staff and these staff changes will enable the Headquarters Office to maintain a high level of performance of day-to-day responsibilities.

Ky. Surgical Society To Meet May 19-20 at Lake Cumberland

The Kentucky Surgical Society will hold its Annual Spring Meeting on May 19 and 20 at Lure Lodge, Lake Cumberland State Park, Jamestown. Approximately 200 guests and members are expected to attend the two-day program which will feature Martin A. Adson, M.D., as speaker.

Doctor Adson

Doctor Adson is Professor of Surgery at Mayo Clinic and is a graduate of the University of Minnesota. He is a member of the American College of Surgeons, American Society of Colon and Rectal Surgeons, American Surgical Association and the Priestly Society.

KAFP Annual Session Set For May 11-13 in Louisville

The Kentucky Academy of Family Physicians will hold its 27th Annual Assembly and Scientific Session on May 11-13 at the Ramada Inn/Bluegrass Convention Center in Louisville. Two business sessions of the Congress of Delegates are scheduled for May 10.

Featured on the program will be outstanding presentations by Kentucky physicians and out-of-state guest speakers on such topics as asthma, arthritis, pediatric diabetes and hypertension, and immunology. The scientific program is acceptable for 12 1/2 hours of prescribed credit by the American Academy of Family Physicians.

The Annual Banquet, to be held May 12 at 7:30 p.m., will feature the installation of officers and an address by Phil Thorek, M.D., Chicago, on "The Press, The Physician, and The Patient."

For further information and registration, contact: Kentucky Academy of Family Physicians, 2211 Medical Arts Building, Louisville, Kentucky 40217.

AOMA President To Speak At Ky. Occupational Mtg.

The Kentucky Occupational Medical Association will hold its 19th Annual Session on May 19-20 at the Ramada Inn at Hurstbourne Lane in Louisville.

The program, which will begin at 1 p.m., Friday, will feature topics of interest directed toward industrial medicine.

The President of the American Occupational Medical Association, Alan A. McLean, M.D., will be the principal speaker at the Friday evening banquet. Doctor McLean, who is Regional Medical Director of the IBM Corporation, New York, will speak on "A Message from the American Occupational Medical Association."

Trustees' Report

SIXTH TRUSTEE DISTRICT
Earl P. Oliver, M.D., Scottsville

At last the snow and ice which has covered the Sixth Trustee District, and also much of all of the Commonwealth of Kentucky since early January, has succumbed to a few brief rays of sunshine and slightly warmer temperatures. Only a few patches of snow and ice remain in shaded areas. Most of the county medical societies have had their annual organizational meetings, and the hospitals and medical facilities are back to their usual routines.

The ground has been broken for the construction of the new Bowling Green-Warren County Hospital and construction which weather permits is in progress. Both Warren County and Barren County are in the investigation and discussion stages regarding the construction of a public coliseum and convention type facilities for their respective counties.

David Fant, M.D., who was previously reported to be practicing in Edmonton is now practicing part-time in Fountain Run, Kentucky. Nicholas R. Birlew, M.D., has recently opened an office in Columbia, Kentucky. We welcome these physicians to our district.

The KMA Board of Trustees, at its March meeting, voted to establish a KMA Insurance Company for the purpose of selling Professional Liability Insurance policies in the following categories: Primary Insurance, Umbrella Insurance, Tail Coverage for those having claims made policies and wishing to change insurors. More information on this will follow from the KMA office. All KMA members are urged to support this KMA company; surely we can serve our profession better and more effectively than our commercial carriers are doing.

FIFTEENTH TRUSTEE DISTRICT
Harold L. Bushey, M.D., Barbourville

This year has been another busy one for the Board of Trustees. After reflecting over the past 5½ years that I have served as the 15th District Trustee, I wish to state that I have enjoyed the opportunity of serving the Association in your interest. However, I still feel that we need more of our members participating in the various aspects of our association. Each member should be active on the local level, and there are opportunities for many to serve on KMA committees. We also need members to be active in the Health

Planning Committees and our HSA. We may not agree with the philosophy but the government has mandated that this is the way of life. Therefore, I believe that we should try and contribute to this process, and try to direct it in the best interest of medicine and our state as a whole. If we are not active in these areas, the mandated majority of consumers will be only too happy to direct our destiny.

In the past six years there has been marked changes in the practice of medicine. Much of this has been brought on by the strong arm of the government reaching further and further into medical care. Our KMA staff and officers have worked tirelessly in an effort to maintain the best possible climate for the practice of medicine in Kentucky. The rest of our society must support them and actively contribute to the effort of maintaining a high quality medical care in a free society.

Members in the news

NEW MEMBERS

BOONE
Jerrold M. Levin, M.D., Florence

BOYD
Jose A. Sanchez, M.D., Ashland

DAVIESS
Shannon Byrd, M.D., Owensboro
Angela Jarvis, M.D., Owensboro

GRAVES
Cletus M. Fernando, M.D., Mayfield
Herbert Lynn Parson, M.D., Mayfield

HARLAN
Fazal H. Ahmad, M.D., Harlan

HENDERSON
Noel Canlas, M.D., Henderson
William W. O'Nan, M.D., Henderson

JEFFERSON
Robert Dyke Acland, M.D., Louisville
Kirby I. Bland, M.D., Louisville
Joseph Wendell Blevins, M.D., Louisville
Bhagwant Borkar, M.D., Louisville
William A. Bradnan, M.D., Louisville
Matilde V. Caing, M.D., Louisville
Ponnattu Cherian, M.D., Louisville
Claire E. Cowley, M.D., Louisville
John C. Diebold, M.D., Louisville
John M. Farmer, M.D., Louisville
Timothy T. Grosser, M.D., Louisville
James I. Harty, M.D., Louisville
John A. Lach, Jr., M.D., Louisville
Robert O. Lindeman, M.D., Louisville
Michael W. McCall, M.D., Iowa City, Iowa
Erlita G. Nazarend, M.D., Louisville
Allan H. Rees, M.D., Louisville
Joseph Sanfilippo, M.D., Louisville
Charles B. Shane, M.D., Louisville
Ronald L. Wathen, M.D., Louisville
James Albert Webb, M.D., Louisville
James P. Welch, M.D., Louisville
Thomas J. Wieman, M.D., Louisville

McCREARY
Michael D. Perkins, M.D., Whitley City

PENNYRILE
Jack Thomas Giannini, M.D., Hopkinsville
Alex Zegarra, M.D., Eddyville

HONORS BESTOWED

Larry N. Cook, M.D., Louisville, was recently named as one of five "Outstanding Young Men" by the Kentucky Jaycees. Doctor Cook, awarded on the basis of his contributions to the community and his profession, is Director of Newborn Services at Norton-Children's Hospitals.

Cecil D. Martin, M.D., Carrollton, was named "1977 Citizen of the Year" by the Carroll County Chamber of Commerce on February 11. A family practitioner, Doctor Martin was cited for recruiting physicians to the area and for his interest in the operation of Carroll County Memorial Hospital.

IN MEMORIAM

LLOYD M. HALL, M.D.
Salyersville
1902-1977

Lloyd M. Hall, M.D., died on December 21 in Bath County at the age of 75. A 1932 graduate of the University of Louisville School of Medicine. Doctor Hall served Magoffin County for more than 40 years as a general practitioner. A 1964 recipient of the KMA Outstanding General Practitioner Award, Doctor Hall had served as Mayor of Salyersville in 1963 and was Chairman of the County Board of Health for many years. Doctor Hall was an Emeritus Member of the Kentucky Medical Association.

PAUL MAPOTHER, M.D.
Louisville
1911-1978

Paul Mapother, M.D., died on February 20 at the age of 66. A practicing dermatologist, Doctor Mapother graduated from the University of Louisville School of Medicine in 1935. A member of the Kentucky Society of Dermatologists, Doctor Mapother belonged to the Jefferson County Medical Society and the Kentucky Medical Association.

LESLIE H. WINANS, M.D.
Ashland
1893-1978

Leslie Haines Winans, M.D., 85, died in February, 1978. An internist, he graduated from Rush Medical College in 1921 and was an emeritus member of the Kentucky Medical Association.

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ELLIS A. FULLER, JR., M.D.
Louisville
1926-1978

Ellis A. Fuller, Jr., M.D., 51, died on February 22. A 1953 graduate of the University of Pennsylvania School of Medicine, Doctor Fuller was an internist specializing in hematology and oncology. An active member of the Jefferson County Medical Society and the Kentucky Medical Association, he was currently a member of the KMA Continuing Medical Education Committee. He had also belonged to the American College of Physicians, the American Society of Hematology, the American Association of Blood Banks, and the American Medical Association.

JAY W. WILSON, M.D.
Louisville
1920-1978

Jay W. Wilson, M.D., died on March 8 at the age of 57. A general practitioner in Jeffersontown for 22 years, Doctor Wilson was a 1954 graduate of the University of Louisville School of Medicine. He belonged to the Jefferson County Medical Society, as well as the Kentucky and American medical associations. He was also an active member of the Kentucky and American Academy of Family Physicians.

THOMAS CLOUSE, JR., M.D.
Richmond
1907-1978

Thomas Clouse, Jr., M.D., died in January, 1978, at the age of 70. A general practitioner, Doctor Clouse was a 1932 graduate of the University of Louisville School of Medicine. He had belonged to the Madison County Medical Society and the Kentucky and American medical associations.

WILLIAM T. ANDERSON, M.D.
Salyersville
1926-1978

William Thomas Anderson, M.D., 52, died during March, 1978. Doctor Anderson was a 1948 graduate of the University of Tennessee and specialized in abdominal surgery. He belonged to the Magoffin County Medical Society and the Kentucky Medical Association.

Did you know . . .

KMA officers and staff have represented the Association daily in Frankfort during the Kentucky General Assembly. Even during the periods of severe bad weather when the Legislators continued to meet, KMA was represented. Beginning with legislative subcommittees meeting as early as 7 a.m., until the two houses adjourned, often late into the evening, KMA's legislative effort was very extensive. It is impossible to say exactly how many man-hours were provided by the officers, committee members and staff, but it was anticipated to be well over 3,500 man-hours. Also, KMA's Key Men were called upon weekly or more often to relate KMA opinions and concerns on impending legislation and to seek their legislator's support on bills of interest to KMA.

☆ ☆ ☆ ☆ ☆

KMA's concern over proposals to amend the Health Planning Law (93-641) and bills relating to hospital cost containment were recently expressed to the Congressional Delegation from Kentucky. The bills opposed by KMA are *H.R. 10460 and S. 2410* (which would apply the Certificate of Need process to physicians' offices, call for decertification of hospitals that are "inappropriate" by standards to be set by DHEW, and would take away the authority of the state under Title 16 of the Public Health Service Act to establish its own plan for facilities' construction) and *H.R. 9717 and S. 1391* (hospital cost containment legislation which would give the Secretary of HEW authority at the federal level to establish utilization rates for hospital services and mandate bed occupancy rates).

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

MARCH

1	Judicial Council, Louisville
2	Commission to Study Health Costs, Louisville
8	Budget Committee, Louisville
	Cancer Committee, Louisville
	Executive Committee, Louisville
9	Board of Trustees, Louisville
	Gardner Campaign Committee, Louisville
13	*Journal* Editors, Louisville
	Jefferson County Medical Assistants, Louisville
18	Legislative Session Ends, Frankfort
30	Continuing Medical Education Committee, Louisville

APRIL

5	Executive Committee, Louisville
6	Board of Trustees, Louisville
10	*Journal* Editors, Louisville
20	Membership and Placement Services Committee, Louisville
25-26	Resident's Workshop, Louisville
26	Judicial Council, Louisville
26-27	Negotiations Seminar, Louisville
28	Interspecialty Council, Louisville

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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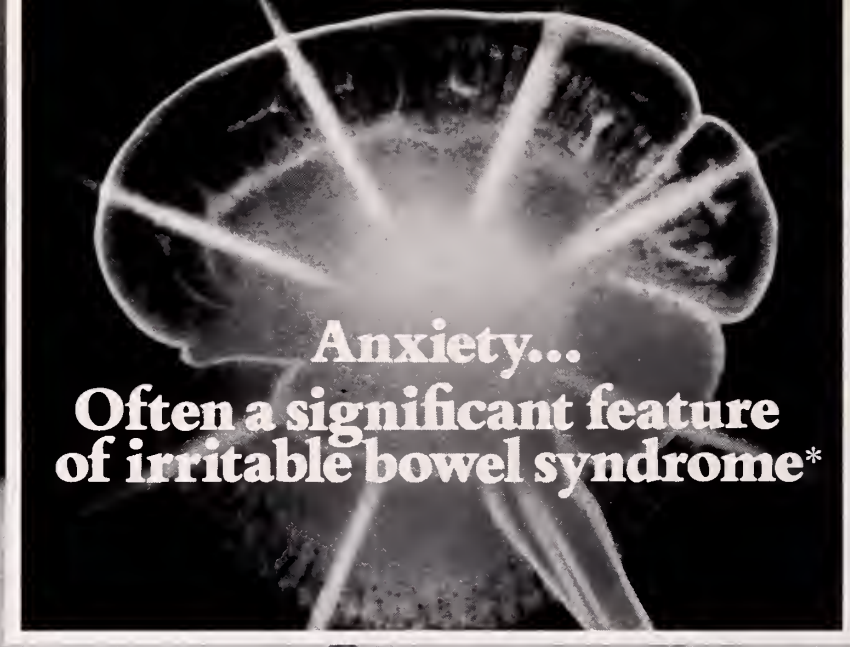

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*Librax has been evaluated as possibly effective for this indication.
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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MESSAGE FROM THE PRESIDENT

Legislation—Where From Here?

HAVING just completed another session of the Kentucky State Legislature, I thought this would be a suitable and timely topic for this editorial.

It is always interesting, and sometimes frustrating, to observe the political maneuvering of the "powers that be" in Frankfort during the session.

It is with amazement that we can watch good dedicated public servants pass legislation which is expensive, at times perhaps potentially dangerous and detrimental to the people of Kentucky, and frustrating that we in medicine have not put enough time and money in proper preparation of our positions to foster their approval.

We in medicine often come up with too little, too late, and it is time for a change.

I would like to encourage each and every physician in the Commonwealth of Kentucky to support medicine in the political arena, equal to the support given by most of our adversaries.

We are being naive when we think that our position and knowledge will suffice to encourage proper political decisions. We also must realize that we must put forth the effort and energy to get our positions before the legislators and to realize that some of them could not care less about our concerns. This will remain true until we manage to show our political strength.

No group of citizens in the Commonwealth can have more influence upon legislation, especially through our patient contacts and personal lobby. So get involved, personally and financially . . . the profession you save may be your own. I hope to repeat this message many times during the next one and a half years.

CARL COOPER, JR., M.D.
KMA PRESIDENT-ELECT

This is the third in a series of articles written at the request of KMA President John P. Stewart, M.D.

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17-19 "Surgical Diseases in Children: Radiologic Evaluation and Operative Correlation*," University of Kentucky College of Medicine, 15 hrs. credit, (Fee: $180, physicians; $90, residents), Hyatt Regency, Lexington

19-20 Spring meeting, Kentucky Surgical Society, Lake Cumberland State Park

19-20 Annual Spring Meeting, Kentucky Occupational Medical Association, Ramada Inn at Hurstbourne Lane, Louisville

20 Cancer Update in the Parks, "Childhood Cancer," Kentucky Division, ACS, General Butler State Resort Park

24-25 "Medical Management and Special Problems in the Treatment of Alcoholism," University of Louisville School of Medicine, Executive Inn, Louisville

24 "Diagnosis and Management of Arrythmias Associated with Myocardial Infarction**," Louisville Area CME Consortium, Health Sciences Center, Louisville

25-26 "Cardiology for the Practicing Pediatrician*," University of Kentucky College of Medicine, 12 hrs. credit (Fee: $85), Hyatt Regency, Lexington

27-28 "Advanced Cardiac Life Support, Instructors Course**," University of Louisville School of Medicine, 18 hrs. credit, (Fee: $125), Health Sciences Center, Louisville

30 "Dizziness**," Louisville Area CME Consortium, Health Sciences Center, Louisville

JUNE

2-3 Fiberoptic Bronchoscopy: A Workshop*, University of Kentucky College of Medicine, 13 hrs. credit (Fee: $250), Hyatt Regency, Lexington

2-3 Sixth Biennial Symposium on "Cancer in Women," Kentucky Obstetrical and Gynecological Society, Galt House, Louisville

3 Cancer Update in the Parks, "Management of Patient with Disseminated Cancer," Kentucky Division, ACS, Carter Caves State Resort Park

7-9 Emergency Medical Care Seminar, Executive West, Louisville

8-10 Wangensteen Symposium on Surgical Management of Visceral and Breast Cancer*, University of Kentucky College of Medicine, 15 hrs. credit (Fee: $150), Hyatt Regency, Lexington

14 "Update on Renal Transplants**," Louisville Area CME Consortium, Jewish Hospital, Louisville

24 Cancer Update in the Parks, "Skin Cancer," Kentucky Division, ACS, Jenny Wiley State Resort Park

28 "Estrogen and Progestational Steroids in the Female**," Louisville Area CME Consortium, Health Sciences Center, Louisville

JULY

24-28 Topics in Maternal/Fetal Medicine, University of Louisville Department of Ob/Gyn, Louisville

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**For further information, contact: Frank R. Lemon, M.D., Associate Dean for Continuing Education, University of Kentucky College of Medicine, Lexington 40506*
***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

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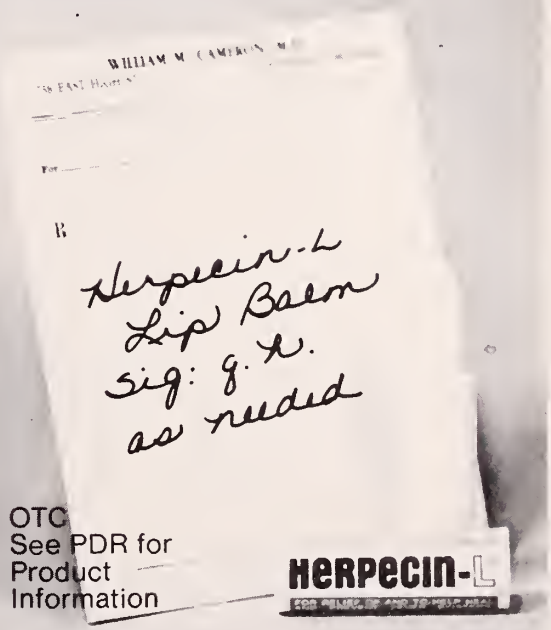

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Applications for space should be received before July 1, 1978.

ACCREDITATION

KAFP allows one credit hour for each hour of participation and presentation of scientific exhibits up to 15 hours. AMA allows up to 10 hours for AMA Category 4 credit.

1. Title of exhibit _____
2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____
3. Institution if other than exhibitor _____
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   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required.)
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7. Has this exhibit been displayed before? If so, when & where? _____

   _____
8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation, and (b) the method, eg., equipment to be used.

Date _____ _____

Signature of Applicant

Fill Out and Mail to:

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- **KMA provides, without cost to the exhibitor, simple shelves, bracket lights and a title sign.**
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- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise should not be used during the general sessions and, at other times, should be controlled by head or earphones or a muffling device.**

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- Vasodilan—compatible with coexisting diseases
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1. For the relief of symptoms associated with cerebral vascular insufficiency.
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Final classification of the less-than-effective indications requires further investigation.

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.
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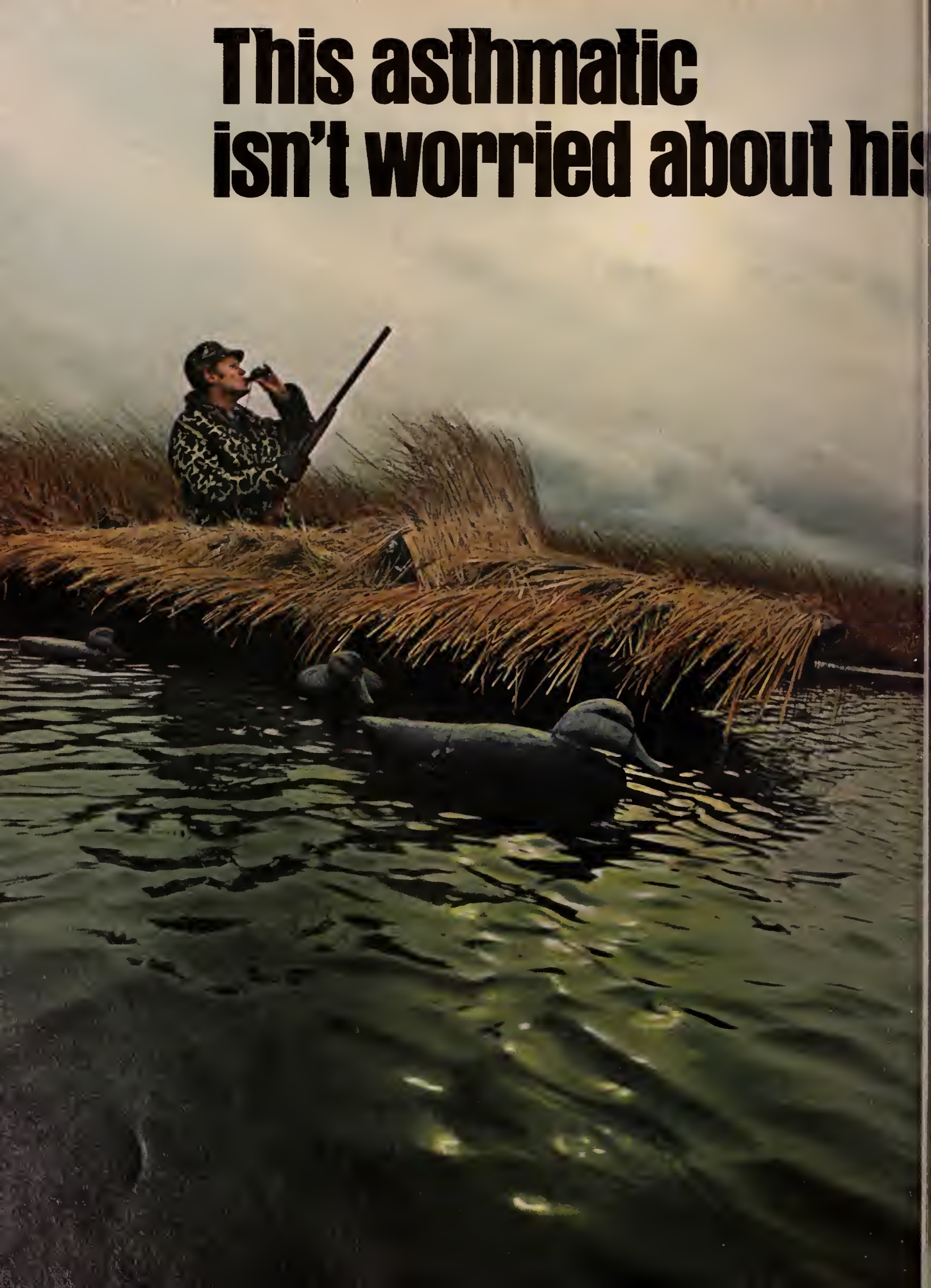

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Evaluation and Management of Vulvar Malignancies

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Improvement of the mortality from vulvar cancer can best be made through a coordinated program of: (1) patient education to reduce delay in seeking medical attention; (2) prompt biopsy of all vulvar lesions; (3) accurate staging of all lesions, and (4) appropriate surgical and combined modality therapy.

CARCINOMA of the vulva accounts for about 3-1/2% to 5% of all female genital cancer. Approximately 81% of these tumors are squamous cell carcinomas, therefore most of the discussion pertains to these lesions. The second most common is the vulvar melanoma. The rest are relatively rare entities (Table 1).

Patients with invasive vulvar cancer typically are elderly with the median age between 60 and 65 years of age. However, it must be remembered that up to 15% of these patients are 40 years old or younger. Many of the clinical characteristics of patients with vulvar cancer are identical to those in patients with endometrial cancer. Approximately 30% of these patients are obese and 25% are hypertensive (blood pressure > 140/90). Other medical diseases commonly associated with vulvar cancer include diabetes mellitus and arteriosclerotic cardiovascular disease. Vulvar diseases reported to predispose a patient to the later development of vulvar carcinoma include the hypertrophic type vulvar dystrophies, a history of poor hygiene, and chronic venereal and granulomatous disease. Approximately 5% of vulvar carcinomas are associated with pre-existing venereal warts, suggesting the importance of a viral oncogenic agent in the etiology of this cancer.

Table 1

Types of Malignant Vulvar Lesions

1.	Squamous cell	81%
2.	Melanomas	11%
3.	Sarcomas	< 1%
4.	Adenocarcinomas	< 1%
5.	Other	~ 6%

Diagnosis

The importance of patient education concerning the symptoms of vulvar cancer cannot be over-emphasized. These tumors are often associated with long-standing symptoms which frequently are ignored by the patient. The most common of these are pruritus and a lump or mass in the area. These two symptoms are reported to occur in over 50% of patients with invasive cancer. It is disturbing to note that in all reported series of cancer of the vulva there is: (1) delay on the part of the patient with symptoms from 2 to 16 months before seeking medical attention; (2) medical treatment of vulvar lesions for up to 12 months by physicians without biopsy for definitive diagnosis or referral.[22,23,25,33] All vulvar

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lumps, ulcers, or pigmented lesions should be biopsied when discovered (Table 2). In the symptomatic patient without a discrete vulvar lesion a simple method of evaluation and directed biopsy is advocated. This should include: (1) staining of the entire area with a 10% solution of toluidine blue; (2) rinsing thoroughly with 1% acetic acid; and (3) taking directed representative biopsies of the areas that retain the stain after rinsing.[1]

Table 2

Indications for Vulvar Evaluation and Biopsy

1. Symptoms
2. A visible ulcer or lump
3. A pigmented lesion
4. Infections or inflammation not responding to therapy

Vulvar Dystrophies

A classification for the vulvar dystrophies is shown in Table 3. The atrophic type (lichen sclerosus) can be treated with 2% testosterone proportionate in petrolatum with good results. A 1% preparation of hydrocortisone cream is effective in the correction of the hypertrophic dystrophy with and without atypia. Friedrich recommends combining crotamiton (Eurax) with the cortisone preparation for the relief of itching. Most of these lesions result from local irritation. Every effort should be made to discover the cause and eliminate it.[17]

Intraepithelial Lesions

The number of patients diagnosed as having preinvasive squamous epithelial lesions of the vulva is increasing.[8] Whether this is due to more physician interest and awareness or actual increased incidence is not known. Most authorities agree that both factors are involved. Many feel that the 35% association between intraepithelial neoplasms on the vulva and cervix suggest an infectious etiology, possibly viral. However, the median age of patients with invasive cervical cancer is 10 years younger than that for patients with invasive vulvar cancer perhaps indicating a difference in resistance of the epithelium of the vulva and cervix to a common oncogenic agent. Management of these entities varies. Isolated cases of spontaneous regression of focal lesions in younger patients that histologically are carcinoma in situ have been reported.[18] Focal lesions, especially in younger patients, without other associated vulvar pathology can be treated by local excision.[8,37] However, the importance of careful follow-up examination, nuclear staining, and indicated biopsy must be stressed. These lesions tend to be multifocal and patients are at an increased risk for local recurrence. For multifocal disease Rutledge, et al, advocate a superficial "skinning" vulvectomy with skin grafting. The results are good with both procedures and normal anatomy is maintained. Some report success with local treatment of multifocal lesions in young patients with 5-Fluorouracil in a cream base. Various regimens have been used. The involved epithelium sloughs and is replaced by normal tissue. This has been confirmed histologically.[2] Corrected cure rates without recurrence should exceed 85% to 90%. Recurrences are treated with surgical excision. There is need for careful follow-up both of the vulva and the cervix in these patients since up to 30% of patients with vulvar lesions will have cervical epithelial abnormalities.

Another well known intraepithelial lesion of the vulva is Paget's disease. These lesions contain the characteristic large round "Paget cells." The origin of this lesion is still controversial even though it was first described in 1874. Some feel that these cells originate in the apocrine glands underlying the vulvar squamous epithelium. This is supported by the association in 30% of cases of Paget's disease and an underlying apocrine gland adenocarcinoma. In contrast, Woodruff believes that Paget cells originate from the undifferentiated basal cell of the squamous epithelium in the stratum germinativum. Embryologically these cells give rise to the skin appendages including the apocrine glands as well as mature squamous

Table 3

Nomenclature of the International Society for the Study of Vulvar Disease

I. Hyperplastic Dystrophy (acanthosis, hyperkeratosis inflammation)
   A. without atypia
   B. with atypia

II. Lichen Sclerosus (thin epithelium, loss of rete ridges subepithelial homogenous zone)
   A. without atypia
   B. with atypia

III. Mixed Dystrophy (areas of both types present)
   A. without atypia
   B. with atypia

IV. Atypia (varying degrees of cellular crowding, nuclear and cytoplasmic abnormalities)
   A. mild
   B. moderate
   C. severe

epithelium.[6,14,30,34] Local excision of this intraepithelial lesion is inadequate. Paget cells will extend in the epithelium beyond the margins of the lesion and local recurrence is a common sequela. It must be treated by total vulvectomy with excision deep enough to eliminate apocrine bearing tissue. If invasion is found on careful pathological examination, inguinal and femoral lymphadenectomy must follow due to the propensity for lymphatic spread.

Invasive Lesions

STAGING

The current clinical staging system for vulvar cancer as defined by the International Federation of Gynecologists and Obstetricians (F.I.G.O.) is presented in Table 4. This system takes into consideration the prognostic parameters of: (1) primary lesion size and extent; (2) the clinical assessment of the regional lymph nodes; and (3) the presence of metastatic disease. The goal of this and any clinical staging system is to allow the clinician using readily available procedures to divide patients with the same disease into groups with different and consistent expected prognoses. Likewise, a uniform reporting system allows variations in therapy to be evaluated by comparing the results of one therapeutic method to another in patients with the same stage of disease.

Patients with lesions less than 2 cm in diameter have an incidence of approximately 15% positive regional nodes. Those with greater than 2 cm lesions have positive nodes almost three times as frequently. When the lesion is confined to the vulva, nodal metastases occur in about 30% of patients. However, when the lesion extends beyond the vulva regardless of its size the incidence of nodal metastases approaches 50%. There is a consistent error of 25% to 30% in the clinical assessment of inguinal lymph nodes. Suspicious nodes are positive 75% to 80% of the time. On the other hand, nodes **not** clinically suspicious harbor occult metastases in about 30% of cases.[4,8,15,23]

Some feel that the staging system for vulvar malignancies should consider other parameters. There is no consideration for lesions involving the midline vulvar structures. The clitoris is known to have direct lymphatic drainage to the deep pelvic nodes. Thus, clitoral involvement would be expected to affect the prognosis adversely.[23] Others advocate that provisions be included for lesions analogous to microinvasive cervical carcinoma, i.e., lesions with invasion less than 3 mm and no confluence or lymphatic or blood vascular involvement.[10,29,36] Even though modification may be needed, the importance of uniform reporting must be stressed for accurate assessment of variations in treatment.

Table 4

CLINICAL STAGING*

Stage I	T1	N0	M0	All lesions confined to the vulva, with a maximum diameter of 2 cm. or less and no suspicious groin nodes.
	T1	N1	M0	
Stage II	T2	N0	M0	All lesions confined to the vulva, with a diameter greater than 2 cm. and no suspicious groin nodes.
	T2	N1	M0	
Stage III	T3	N0	M0	Lesions extending beyond the vulva but without grossly positive groin nodes.
	T3	N1	M0	
	T3	N2	M0	Lesions of any size confined to the vulva and having suspicious or grossly positive groin nodes.
	T1	N3	M0	
	T2	N3	M0	
	T1	N2	M0	
	T2	N2	M0	
Stage IV	T3	N3	M0	Lesions extending beyond the vulva with grossly positive nodes.
	T4	N0	M0	Lesions involving mucosa of rectum, bladder, or urethra, or involving bone.
	T4	N1	M0	
	T4	N2	M0	
	M1A			All cases with distant or palpable deep pelvic metastases.
	M1B			

* F.I.G.O., 1971

MELANOMA

Malignant melanoma accounts for approximately 1% of all cancers in the United States. The majority occur in fair complexioned, blue-eyed persons. Although the vulva constitutes only 1% of the body surface, 5% of malignant melanomas originate in this area. The incidence increases with age and occurrence may be familial. The most common symptoms are: (1) the presence of a tumor or enlarging mole; (2) pruritus; and (3) bleeding. Melanotic lesions tend to occur on the labia minora and clitoris in contrast to squamous cell carcinomas which tend to occur on the labia majora. The vaginal mucosa is involved more often than in squamous carcinomas. The vagina and urethra are involved in about 9% of these cases and this type of involvement carries a poor prognosis. Inguinal node metastases are noted in approximately 30% of all cases. As in

other vulvar malignancies, prognosis is related to the extent of the disease. Survival in Stage I and II may be as high as 75%. Five-year survival with negative inguinal nodes is 56% and with positive inguinal nodes it is approximately 14%.[27]

It is well known that the junctional nevus is a precursor to malignant melanoma. Virtually, all vulvar nevi are of this type. Therefore, all pigmented lesions on the vulva should be removed with a margin of normal skin on all sides and submitted for pathological examination. If melanoma is diagnosed, irrespective of the lesion size, depth of invasion, or extension a radical vulvectomy and bilateral groin dissection are the minimum of accepted treatment. Many feel that with vulvar melanomas deep pelvic lymph node dissection should be done routinely. Malignant melanoma and sarcoma have been reported to demonstrate a very low degree of radiosensitivity and surgical management has been recommended. However, some studies have suggested that radiation therapy is effective against small vaginal melanomas, and in one recent study a good five-year survival was obtained by a combination of surgery and irradiation.[9]

Several drug regimens have been utilized recently in the treatment of patients with disseminated melanomas. The most beneficial are the alkylating agents which have been reported to have 14% to 22% response rate. However, this disease is resistant to permanent control chemotherapeutically.[26]

It has been estimated that 3% to 6% of primary melanomas may regress spontaneously.[24] This occurrence suggests that host immune response to melanoma antigens may be important in the eradication of local and even systemic disease. Variable success has been noted in patients with normal levels of immunocompetence with the direct injection of BCG into tumor nodules. Tumor nodules have locally regressed following BCG injection, but systemic disease has not been cured and patient survival has not been appreciably increased. It must be remembered that from the best estimates that we can obtain the normal immune surveillance mechanism is capable of destroying only approximately 10^5 neoplastic cells. Thus the principle role of immunotherapy to date in any situation is as an adjunct to surgery, radiation therapy, or chemotherapy.

SARCOMA AND ADENOCARCINOMA

Sarcoma of the vulva is a very rare disease. It accounts for probably less than 1% of all vulvar cancers, but is important in the differential diagnosis of vulvar lesions in children. It occurs earlier than squamous cell carcinoma with the median age between 35 and 38 years. The usual symptom is pain either from local pressure or coitus. Leiomyosarcoma is the most frequent type seen. It is a slowly growing tumor with late local recurrence. In contrast, embryonal rhabdomyosarcoma which is the most common childhood gynecologic sarcoma, is very rapidly growing and metastasizes early in its course. As with most sarcomas, the prognosis is guarded regardless of therapy. Surgical therapy consisting of radical vulvectomy and groin dissection has been the primary method of attack. Recent reports, however, utilizing multiple modality therapy with triple agent chemotherapy (Vincristine, Actinomycin-D, and Cytoxan), local surgical removal, and regional radiotherapy, have produced encouraging results in childhood sarcomas.[11]

The rarest invasive malignancy of the vulva is adenocarcinoma.[12] It usually arises from the Bartholin gland and tends to occur in elderly patients. In this age group, swelling and inflammation of the Bartholin gland due to an inflammatory process is unusual, and all lesions in this area should have immediate evaluation. The subcutaneous location and deep lymphatic drainage of these tumors tend to make them more advanced at the time of diagnosis than superficial tumors. It is recommended that radical vulvectomy with inguinal lymphadenectomy be performed. Because of direct lymphatic drainage to the deep pelvic lymph nodes therapy to the pelvis is recommended.

Treatment

The therapy for invasive squamous cell carcinoma of the vulva is radical vulvectomy and bilateral inguinal and femoral lymph node dissection. Some authors advocate routine pelvic lymphadenectomy. Most authorities feel however, that pelvic node dissection should be used selectively because of: (1) the increased operating room time and morbidity associated with pelvic lymphadenectomy; and (2) evidence that the added procedure and its inherent risks were lifesaving only in a very few patients. In many large series, notably those of Morley, Rutledge, Symmonds, and Green no positive pelvic nodes have been found in the absence of positive superficial inguinal or femoral nodes.[25,33] This has been true

Table 5

Indications for Treatment of Pelvic Lymph Nodes in Vulvar Cancer

1. Positive groin nodes
2. Bulky primary lesions with extension to the vaginal mucosa, urethra, and/or anus
3. The primary lesion is a melanoma or adenocarcinoma

even with clitoral involvement. In patients with vulvar cancer who have positive pelvic nodes, it has been noted that either the primary lesion was not accurately described or was larger than initially noted with extension onto or near the adjacent urethra, vaginal mucosa, or anus. Extremely aggressive tumors such as melanoma or adenocarcinoma have been reported to involve deep pelvic nodes in the absence of superficial inguinal spread. It would thus seem reasonable that the deep pelvic nodes should be treated when: (1) there are positive groin nodes; (2) when the primary lesions are very bulky and infringe upon the vaginal mucosa, urethra, and/or, anus; and (3) the primary lesion is a melanoma or adenocarcinoma. In the presence of positive pelvic nodes; however, very few survive in spite of surgical removal.

The effectiveness of treatment in patients with positive regional nodes is cause for concern. Recent studies indicate a corrected survival in patients with positive nodes to be about 30%. If pelvic nodes are positive the results are very poor with a survival of less than 10% to 15% in most series despite pelvic lymphadenectomy. The value of routine inguinal lymph node dissection for invasive vulvar cancer is emphasized by data such as that of Morley which shows a corrected five-year survival of 95% in patients with Stage I and II disease undergoing radical vulvectomy and bilateral groin dissection as compared with 60% for radical vulvectomy alone. However, pelvic node dissection has been shown to benefit few patients (approximately 2/100) with positive nodes.[25] The effectiveness of radiation therapy in cervical cancer to the deep pelvic nodes is recognized. Six-thousand rads can eradicate tumor nodules approximately 1 cm. in diameter. This dose can safely be delivered from a high energy skin sparing source to the external iliac, obturator, and hypogastric nodes. With these considerations in mind, a protocol is being developed at the University of Kentucky Medical Center utilizing postoperative deep pelvic external irradiation from a linear accelerator in patients: (1) with positive groin nodes; (2) with lesions involving the urethra, vaginal mucosa, or anus; and (3) vulvar adenocarcinoma and melanoma. In patients likely to have large deep pelvic nodes containing tumor, such as those with large fixed inguinal nodes, exploration is carried out to debulk large tumor masses. Hopefully, this method will be better tolerated and more effective than pelvic lymphadenectomies in selected patients with invasive vulvar cancer.

Summary

Improvement of the mortality from vulvar cancer can best be made through a coordinated program of: (1) patient education to reduce delay in seeking medical attention; (2) prompt biopsy of all vulvar lesions; (3) accurate staging of all lesions; and (4) appropriate surgical and combined modality therapy.

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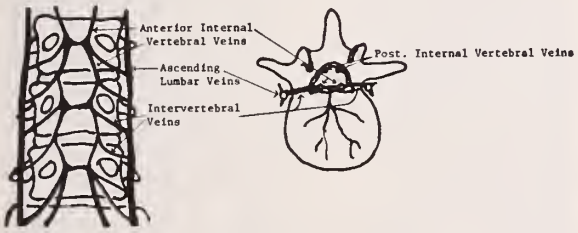

FIG. 1. Diagram of vertebral venous anatomy.

Epidural venography may be used as the primary diagnostic tool when symptoms persist, but is usually performed after a normal myelogram. Myelography may fail because the pantopaque column does not cover the area surrounding the lesion. For example, nearly all false negative myelograms have been at the L5-S1 level[8-14] where there is a wide epidural space or, in some cases, termination of the thecal column above that level. Laterally herniated discs are also especially difficult to demonstrate on myelography, possibly because the nerve root is compressed after leaving the subarachnoid space in which the pantopaque remains.[3]

In addition to its reliability, venography is a simple, safe procedure which usually causes the patient mild discomfort during the examination. Notable is the absence of post-procedure headache that follows myelography. Most patients tolerate the procedure well and find it a less traumatic experience than a myelogram. In our experience, epidural venography is easily accomplished on an outpatient basis. No complications

FIG. 2. Normal epidural venogram. Anterior epidural veins (open arrowheads). Ascending lumbar vein (curved open arrow). Intervertebral or radicular veins (closed black arrow).

Doctors Drasin, Schwab, Short, Tyson, Wheeler and Tittel are from the Department of Radiology at Jewish Hospital in Louisville. Ms. Cooke is from the University of Louisville School of Medicine, Louisville.

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*FIG. 3A. Myelogram normal but an extremely wide epidural space present at L5-S1. The AP film was also normal.

have been reported in the literature, and we have experienced no complications in our patients.

Anatomy

Vertebral venous anatomy is described in detail in several articles,[2-4] but for the reader's convenience, a brief review follows.

The venous system which drains the axial skeleton, its contents, and musculature, consists mainly of two valveless networks: the internal vertebral veins (epidural veins) which run within the spinal canal and the external vertebral veins (paravertebral) which communicate with the caval system at numerous locations.

Within the spinal canal, two pairs of vertical veins, the anterior and posterior internal vertebral veins, joined by segmental cross connections, form an envelope of vessels around the dural sac (Fig. 1 and 2). The posterior veins lie ventral to the vertebral arches, relatively remote from the disc space and are of little value in this procedure.

Venographic diagnosis depends primarily upon the appearance of the anterior internal vertebral veins and the lateral intervertebral branches which connect them above and below each pedicle to paravertebral channels. Disc herniation can compress, divert, or obstruct the anterior internal vertebrals which lie on the posterior surface of the vertebral bodies and intervertebral discs. Discs can also affect the intervertebral branches (also called radicular and supra or infrapedicular veins) which accompany nerve roots leaving intervertebral foramina.

Though variations in venous patterns are common, they usually involve number and size rather than presence or absence of veins and each patient normally possesses side-to-side and level-to-level similarity.[3]

Technique

A 5 to 6f celiac end hole catheter is introduced into the femoral vein on the contralateral side of the patient's symptoms. It is advanced over the iliac vein bifurcation with the aid of a guide wire to the internal iliac vein and from there into a sacral vein which connects to the epidural plexus.

*FIG. 3B. Epidural venogram shows marked straightening of left epidural vein (straight arrow) with oblique displacement and obstruction of radicular vein (curved arrow).

Reprinted by permission Am J Roentgenol 125:6, May, 1976.

Alternate sites of injection are the ascending lumbar veins or azygous veins. Injection of 4-5cc/sec for a total of 40cc is made while the patient performs a hard valsalva maneuver with a compression band placed across his abdomen. A film is taken every second for 12 seconds.

Case Report

J. B., a 26-year-old man, developed sudden onset of low back pain which radiated into his left leg, two weeks prior to admission. On physical examination, weakness was noted of the extensor hallicus longus on the left. The myelogram was considered normal but an extremely large epidural space was present (Fig. 3A). An epidural venogram (Fig. 3B) demonstrated deviation and straightening of the left anterior veins at L5-S1. At surgery, a protruding disc was excised from L5-S1.

Comment: This case emphasizes the value of epidural venography when a wide epidural space is present.

Summary

Epidural venography has been found to be a safe, effective, and accurate method of detecting lumbar disc herniation particularly in the face of persisting symptoms and a normal or equivocal myelogram.

Acknowledgements

We wish to thank Mr. Dan Smith for photographic assistance, Mrs. Sylvia Green for clerical help and to Ms. Addie Beasley, R.T., Miss Nancy Howlett, R.T., and Ms. Linda Oswein, R.T. for technical help.

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Histoplasma Reactors in a Family Practice

James L. Ferrell, M.D., E. W. Chick, M.D., Ian J. D. Caisley, M.D., and Woodford Van Meter, B.S.

Paris, Kentucky

Histoplasmosis is a common infectious disease in Central Kentucky. The prevalence in a family practice in a Central Kentucky community is presented along with follow-up CFT results.

RESEARCH of literature reveals no estimate of histoplasma reactors in a family practice. Previous estimates of reactors have been done in selected age groups, i.e., pediatric practice, college physicals, and grade school children. From the national level, it has been estimated that 40,000,000 people have histoplasmosis at the rate of approximately 500,000 annually. In a survey of state reactivity, Kentucky leads the nation in percentage of positive reactors with a statewide average of 67.3%, followed by Tennessee with 65.1%, Arkansas with 57.8%, and Missouri with 53.4%. In Kentucky, the percentage of reactors in the Bluegrass area averages as high as 90% positive, the Southwestern area of the state, 75%, and the Eastern area, 25%. On a local level, no studies have been done to show how many people have positive skin test reactions in a private practice. The purpose of this study was to do a random survey of patients in one private practice to obtain an estimate of positive reactivity within a general population.

Methods

The subjects for this study were randomly-selected, walk-in patients in the private practice of James L. Ferrell, M.D., in Paris, Kentucky. Skin tests were given on Mondays, Tuesdays, and Wednesdays. These tests were read 48 hours later. There were no selection factors. Exclusion factors were the elimination of patients under six months of age, patients with acute or chronic skin inflammation, or patients with severe respiratory disease. Patients coming in on Thursday or Friday were not administered skin tests.

Skin tests were administered with 0.1 ml. HKC 43 antigen. HKC 43 was injected intradermally in the ventral surface of the left forearm with a 26 gauge 3/8″ needle using a 1 cc syringe. Patients were given no special instructions, were to ignore itching or rash resulting from the skin test, and were to return in 48 hours to have the test read by office personnel. A positive test was an area of induration at least 5 mm in diameter within an erythematous region. No attempt was made to follow patients who did not return in 48 hours for reading.

Results

Of 213 patients to whom skin tests were administered, 193 patients (91%) returned for reading. Of the 193 patients returning, 119 (62%) had positive tests by the criteria described. (Table 1) Test results by age as seen in Table 1 reveal an increasing prevalence of reactivity starting at near zero in infancy and increasing to a peak in the 10-19 age group at 79%. The number of reactors declined with increasing age past 29. We noted that 29% of preschool children (2 of 7) ages 0 to 5 were positive reactors but that this prevalence increases up through age 20 to 29 peaking at 85% with a smooth curve drawn through the date points. (Table 2) After age 40, there was a steady decline to 20% in the over 80 age group. Sex differential showed 45 of 80 (56%) males were positive reactors while 74 of

Table 1

TEST RESULTS BY AGE

Age	Positive	%	Negative	%	Total
0- 5	2	(29)	5	(71)	7
6- 9	4	(50)	4	(50)	8
10-19	19	(79)	5	(21)	24
20-29	31	(66)	16	(34)	47
30-39	20	(74)	7	(26)	27
40-49	21	(81)	5	(19)	26
50-59	11	(52)	10	(48)	21
60-69	9	(45)	11	(55)	20
70-79	1	(13)	7	(87)	8
80-89	1	(20)	4	(80)	5
Totals	119	(62)	74	(38)	193

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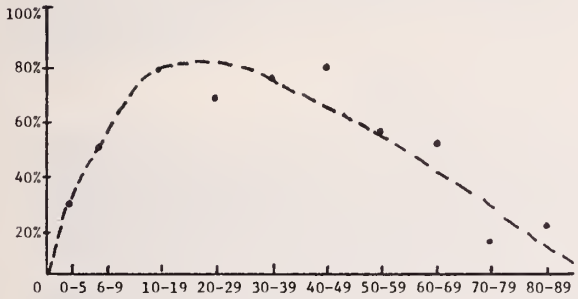
Table 2

PERCENT POSITIVE TESTS BY AGE



113 (65%) of females were positive reactors. (Table 3)

Complement fixation tests were done on 23 randomly selected patients of the 119 reactors in our study and blood titers are listed in Table 4. Positive CFT's were found in 13 of the 25 reactors. These titers ranged from 1:8 to 1:32.

Patients with positive CFT's will be followed by x-ray examination of the chest and repeat CFT's in six months. Patients with respiratory symptoms or abnormal chest x-rays will have sputum examinations.

Discussion

The most significant feature noted in our study was the skewed bell-shaped curve of age group reactivity seen in Table 2. The reactivity peaked at the 20 to 29 age group at approximately 80% according to the curve, whereas the actual percentage of reactors in our study was 66% for this age group. There was significantly less reactivity below the age of 10 and over age 39. The discrepancy between our point and the curve for the 20-29 group is likely due to the small numbers in age group subpopulations. Table 2 shows a curve drawn through our data points showing maximum reactivity between the ages of 20 and 29. Such a curve is comparable to results of previous surveys.

Table 3

SEX RATIO

	Positive	Negative	Total
Males	45	35	80
Females	74	39	113
Totals	119	74	193

The small numbers of candidates in the under 10 and over 50 age groups could affect the shape of the curve. It cannot be determined from our data whether the slope of the curve decreased to approach 0% with increasing age over the entire graph or increased up to age 70 and then leveled off at approximately 20%. Possible explanations for the down slope of the curve with increasing age could be (1) loss of reactability with increasing age which is compatible with previously documented decreasing ability to generate an immune response, (2) the small numbers that we surveyed in these age groups, and (3) different patterns of infection with variations in the past from the current histoplasma antigen which might have affected the older age group.

Table 4

Complement Fixation Tests on 23 of 119 reactors

1:0	10
1:8	5
1:16	6
1:32	2

Summary

We found in a survey of 193 patients given histoplasmosis skin tests with HKC 43 antigen that 119 (62%) were reactors. There was a difference in age group reactivity increasing to a peak in the 20's with approximately 80% and diminishing with increasing age. Possible explanations for the decrease in reactivity are (1) loss of reactivity with increasing age, (2) small numbers of patients in the younger and older subpopulations of our study, and (3) different age coherts or patterns of infection. This study provides an estimate of positive reactors in a small town family practice. Further study of reactors in this area is invited among other family practices.

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Editors Note: *There is a great deal of controversy about the use of the histoplasma skin test as a diagnostic tool.*

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The University of Louisville School of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interest to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

Upper Airway Obstruction Resulting in Cor Pulmonale

UPPER airway obstruction is the most common cause of respiratory distress in children. Although respiratory distress in these children is due to inadequate ventilation, other manifestations of airway obstruction occur. Significant cardiopulmonary problems manifest as right heart failure and even cor pulmonale have been reported.[1] Our recent experience with a patient who presented several times with upper airway obstruction and associated right heart failure prompted us to review the literature and report our experience with tracheal obstruction.

Case Report

A six-week-old infant was admitted to another hospital with a history of cyanosis. At birth, he was apneic, had low apgars, and sustained paralysis of II-XII cranial nerves on the right side. He was discharged at three weeks of age. Three weeks later, he was readmitted with cyanosis and severe pneumonia. He developed empyema which required decortication of the pleura. Tracheostomy and feeding gastrostomy were introduced.

Following discharge from the hospital he had frequent upper respiratory infections. He was fed through the gastrostomy tube because of difficulty in swallowing. At 20 months of age, he was admitted to Norton-Children's Hospital for evaluation of decannulation of trachea. Bronchoscopy disclosed virtually no stenosis or granulation tissue in the trachea. The tracheostomy was removed without difficulty and the patient was discharged.

At 36 months of age he was readmitted to another hospital. He had a ten-day history of upper respiratory infection. Physical examination disclosed edema of the hands and feet, mucoid secretions from the lungs, and marked chest retraction. The patient was in congestive heart failure with cardiomegaly and hepatomegaly. He was treated with digitalis and diuretics without any improvement. He was transferred to Norton-Children's Hospitals for further management.

Physical examination at admission revealed tachypneas and substernal retraction. He was noted to be in congestive heart failure with marked right ventricular lift. S1 and S2 were markedly increased. The liver was enlarged 9 cm below the right costal margin. Electrocardiogram showed right atrial hypertrophy and right ventricular hypertrophy with right axis deviation.[1] Chest roentgenogram revealed cardiomegaly with normal pulmonary vasculature and some chronic infiltrate.[2] Cor pulmonale secondary to acute airway obstruction was suspected and the patient was intubated. Within six hours after intubation the liver had decreased in size 3 to 4 cm below the

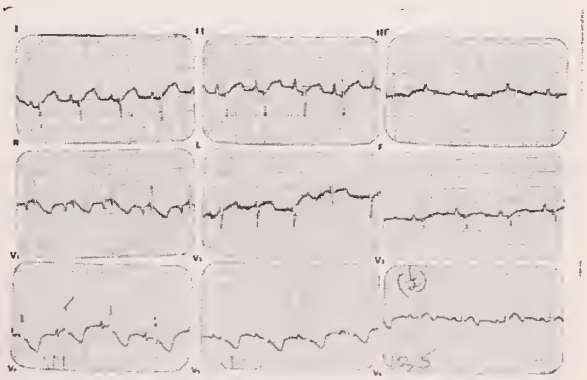

FIG. 1 EKG reveals right axis deviation, right atrial hypertrophy and right ventricular hypertrophy.

From the Department of Surgery, University of Louisville School of Medicine, Health Sciences Center, Louisville, Kentucky.

FIG. 2 PA chest roentgenogram shows cardiomegaly and increased pulmonary vasculature.

right costal margin. There was less right ventricular lift. The S1 and S2 were discussed in intensity and there was no splitting of S2. Three days later laryngoscopy and bronchoscopy confirmed vocal cord paralysis of the right side and tracheal stenosis secondary to granulation tissue at the tracheostomy site. The tracheostomy tube was reinserted and the patient improved during the ensuing two weeks. At the time of discharge chest roentgenogram was normal although EKG still showed right ventricular hypertrophy.

At 3½ years of age, the patient was readmitted with a one-day history of upper airway obstruction and upper respiratory infection. Physical examination and chest roentgenogram revealed borderline cardiomegaly. By administering the proper antibiotics and using a larger size of tracheostomy tube to clear the tracheal and pulmonary secretions, the patient promptly improved and was discharged.

He was admitted six months later with pseudomonas infection of the lung and trachea and right heart failure. He required frequent suctioning of the trachea, mechanical ventilation, diuretics, and a tracheostomy tube larger than what was previously utilized. The pseudomonas infection was treated with carbenicillin and gentamicin. The patient required placement of Swan-ganz catheter for proper monitoring. His pulmonary artery pressure, when he was in cor pulmonale, revealed blood pressure of 60/30. The patient recovered three to four weeks after intensive treatment.

Discussion

Upper airway obstruction, a common problem during childhood, is most frequently seen during the second, third, and fourth years of life[2] and may be classified as acute or chronic (Table 1). The signs and symptoms are stridor, wheezing, and substernal and intercostal retraction. Chronic airway obstruction is a silent process which is often recognized clinically only after the associated problems are accentuated by an acute upper respiratory infection. Although infrequently reported in the literature, pulmonary hypertension associated with upper airway obstruction is a well recognized problem. DJalilian et al[3] reviewed 27 cases of pulmonary hypertension with or without resultant cor pulmonale and right ventricular heart failure. One of these cases was secondary to upper airway obstruction caused by enlarged tonsils and adenoids. A total of 46 cases concerning enlarged

FIG. 3 Two weeks after intubation PA chest roentgenogram shows normal heart size and decreased pulmonary vasculature.

Table 1

ETIOLOGIC FACTORS OF AIRWAY OBSTRUCTION

Acute	Chronic
Croup	Subglottic stenosis
Infections	Congenital
Post-intubation	Acquired
Epiglottitis	Vocal cord paralysis
Foreign body	Vascular ring
Burns	Granuloma
	Tumors

tonsils and associated pulmonary hypertension have been reported in the literature.[3,4]

There are two basic mechanisms of cor pulmonale in the child: alveolar hypoventilation and a reduction of the pulmonary vascular bed secondary to disease of the lung.[5,6] Those patients with tracheal obstruction who develop associated cor pulmonale appear to have blunted response to hypercapnea and a decreased pulmonary vascular bed. This implies that both mechanisms of cor pulmonale are involved. Figure 4 shows diagrammatically the pathophysiology of upper airway obstruction causing pulmonary hypertension. Respiratory rate does not increase in response to hypercapnea. This leads to acidosis and hypoxia which in turn lead to pulmonary vasoconstriction and cor pulmonale. By proper relief of airway obstruction, changes can be reversed without advanced histopathologic changes.[7]

Sedation and the routine use of oxygen therapy without mechanical ventilation are associated with high risk and should be utilized only with careful monitoring in the controlled environment of an intensive care facility. Sedation can suppress the respiratory drive and cause further hypoventilation.[4] Oxygen therapy without respiratory assistance can diminish the hypoxic drive or further increase hypercapnea.[4] Respiratory arrest and death are real problems associated with sedation or indiscriminate oxygen therapy.

Table 2

CAUSES OF AIRWAY OBSTRUCTION IN 55 PATIENTS

Cause	No. of Patients
Subglottic stenosis	17
Foreign body	13
Tracheomalacia	4
Epiglottitis	8
Tumors	3
Bronchial stenosis	2
Granulation tissue at old tracheostomy site	2
Miscellaneous	6
Total	55

A review of upper airway obstruction at Norton-Children's Hospital from 1975 to the present time (Table 2) has been presented. In this series, one patient fit our criteria for pulmonary hypertension secondary to tracheal obstruction. Following endotracheal intubation, this patient had a dramatic improvement of his condition. Reestablishment of his tracheostomy facilitated resolution of his right heart failure, whereas medical management with digitalis and diuretics failed to procure improvement. Decrease in the size of the heart and liver was documented by physical examination and chest roentgenogram, even though the EKG had not improved.

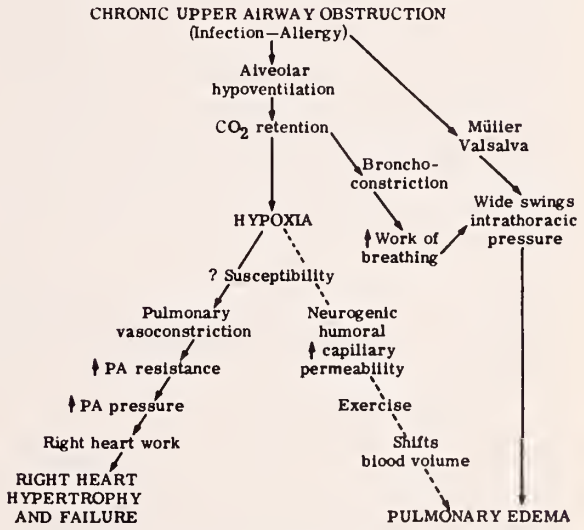

FIG. 4 Pathophysiology of cor pulmonale in airway obstruction. [By permission of American Academy of Pediatrics, Inc. (Luke, M.J., Mehrizi, A., Folger, G.M., Jr., et al.: Chronic Nasopharyngeal Obstruction as a Cause of Cardiomegaly, Cor Pulmonale, and Pulmonary edema. Pediatrics 37:762-768, 1966.) and Mayo Clinic Proceedings (Djalilian, M., Kern, E.B., Brown, H.A., et al.: Hypoventilation Secondary to Chronic Upper Airway Obstruction in Childhood. Mayo Clin. Proc.:50:11-14, 1975.)]

This patient has chronic lung disease, but only to a minimal degree and not severe enough to cause the degree of cor pulmonale seen. His problem over the last 12 months has revolved around recurrent upper respiratory infections and pneumonia and a functionally obstructed airway. The patient was inactive and lethargic. Examinations revealed hepatomegaly and oftentimes cardiomegaly. Follow-up EKG's have continued to show right ventricular hypertrophy and right

atrial hypertrophy, probably indicative of the ongoing respiratory problem secondary to infections, marked secretions, and functional airway obstruction.

Summary

A 3½-year-old child presented with acute right heart failure and cor pulmonale secondary to tracheal obstruction. Resolution of the airway obstruction resulted in improvement although the child has continuing problems with frequent mucoid secretions of the tracheobronchial tree which has prevented complete resolution of his problem.

Upper airway obstruction is seen frequently by the clinician and may present as a very mild obstruction or an acute life-threatening incident. Conversely, when congestive heart failure seems refractile to medical management, the possibility of acute or chronic airway problems must be investigated thoroughly. Diuretics and mechanical ventilation may be necessary in severe cases. Digitalis plays a very small role in right heart failure. The resolution of the airway obstruction is often needed to resolve the problem of cor pulmonale.

PATRICK D. MULLENS, M.D.
H. S. NAGARAJ, M.D.
GORDEN T. MCMURRY, M.D.

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EDITORIAL

Physician's Assistants

A REPORT from the director of the Clinical Associate Program, College of Allied Health Professions, University of Kentucky, is published in this issue of *The Journal*. We hope the membership will study this paper carefully and we are grateful to Doctor Hal T. Wilson for the timely contribution which should be of deep interest to us all.

The KMA has affirmed its approbation of the concept of the physician's assistant since the establishment of the Clinical Associate Program in 1973 and U.K.'s development and evolution of the program has been conscientious and enthusiastic. Doctor Wilson cites the widespread official recognition of the concept of physician's assistants and correctly refers to the "pursuit of the experiment." These students are being taught and trained in close proximity with practising private physicians who are making careful, large contributions to the program and we feel this interdependence is crucial to the favorable outcome of the experiment.

While the faculty of the College of Allied Health Professions and the private practitioners who serve in training the students struggle to effect a two-year curriculum that will evolve a productive addition to health care, attention must also be directed to the information and training of physicians. They must learn how to work with and supervise the physician's assistant so that the assistant's training is fully realized, the physician's influence is maximally expanded and the patient's health and convenience are in reality improved.

Kentucky's physicians are interested in the details of curriculum and assessments of the final product and refinements of performance of physician's assistants. *The Journal* wants to contribute in all ways to informing our practitioners what to expect and how to utilize these new instruments. We hope to have additional contributions from both universities and would welcome information from personal experience, observations and questions in letters from the membership.

AEO

The SMA

MOST of us feel we don't need another organization to join or another meeting to attend. However, there is one organization that you should seriously consider. A list of characteristics of a group is purely dull reading, but bear with me and I'll be brief.

The Southern Medical Association is a regional organization whose specific purpose is to develop and foster scientific medicine. This group shall not at any time take active part in any economic, political or sectarian questions. The active membership of approximately 25,000 is drawn from 17 southern states.

Kentucky physicians have been active in the affairs of the Southern since shortly after its founding in 1906. Previous SMA Presidents from Kentucky include: Irvin Abell, M.D.—1933, Arthur T. McCormack, M.D.—1940, James A. Ryan, M.D.—1944, Elmer L. Henderson, M.D.—1947, A. Clayton McCarty, M.D.—1962, Andrew M. Moore, M.D.—1975.

Past Councilors for Kentucky include J. Duffy Hancock, M.D., Sam A. Overstreet, M.D., Andrew M. Moore, M.D., and Hiram C. Polk, Jr., M.D. The present associate councilors are Cecil L. Grumbles, M.D., Paul F. Maddox, M.D., William R. Meeker, Jr., M.D., Robert Schiavone, M.D., and William P. VonderHaar, M.D.

The 1978 Annual Meeting will be held November 11-14 in Atlanta in conjunction with the

Medical Association of Georgia. This year's meeting is conveniently located and ranks high as a program enjoyed by physicians and their wives. Scientific sessions feature papers from all specialties. The presentations are directed to the current problems of clinical medicine and do not lean heavily toward research.

Membership dues are $50 a year and some of the benefits include a subscription to the *Southern Medical Journal,* availability to the Dial-access program, and an excellent insurance program. Considering the rapid rise in dues of other organizations, this is a "good deal!"

Join us in Atlanta this year and see if you don't want to add to the 1,000 of 3,000 Kentucky physicians who belong to the SMA.

Robert G. Overstreet, M.D.
Councilor for Kentucky
Southern Medical Association

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SPECIAL ARTICLES

Present Status of the University of Kentucky Clinical Associate Program

Hal T. Wilson, M.D.

THERE are approximately 9,000 graduate physician's assistants working with the nations' doctors at the present time. They are educated in 53 college and university programs which are accredited by the Allied Health Education Committee of the American Medical Association and about 1,300 students graduate yearly. At least 44 states now have legislation recognizing this concept and generally allowing full expression to the pursuit of the experiment.

At the University of Kentucky, the Clinical Associate Program, which began training physician's assistants in 1973, has 45 graduates working in the state. There are presently 40 students in the 24-month training period.

The prime objective of the educational process here is to develop new health practitioners who are thinking, non-physician clinicians capable of assisting doctors in the evaluation and care of patients. A second objective provides that every effort be made to select and encourage students willing to work in regions of medical care need.

Program Curriculum—Phase I

Attempts to educate superior primary care physician's assistants within a two-year time frame have led to the use of innovative educational methods. The Kentucky curriculum includes the use of self-instructional units which integrate basic science and clinical learning in the same fashion as the physician does when performing evaluations of the patient. Phase I also includes almost immediate clinical experience to allow students to start evaluating patients with problems related to each system under study. Learning occurs in small groups with instructor guidance at the bedside. Support of this method of educating clinicians has come from physicians in private practice when they reflect upon the difficulty of recalling a two-year mass of information from basic science training and applying it during the final clinical years of medical school curriculums. Further, the educational tactics of applying knowledge while learning, using group inquiry and immediate feedback allow for greater retention of concepts and their utilization in the medical process. In addition to medical science units there are courses in interviewing and interpersonal skills, human growth and development, pediatrics, psychiatry, radiology, laboratory utilization, and anatomy. The entire curriculum is circumscribed to embrace just about 100 of the most frequently encountered problems of family practice.

Phase I of the program lasts nine months and one of the goals is to prepare the student for a smooth transition into the clinical year. To achieve maximum learning the student must enter the second phase of education with an ability to communicate with the patient well enough to obtain a valid history, to perform an accurate physical examination, and to define the patient's problems in satisfactory descriptive terms.

Clinical Training—Phases II and III

Clinical experience during the second phase includes eight weeks of family practice and five weeks each on rotations essential to primary and family medical care. Of these, medicine, pediatrics, and emergency room care take place at Medical Centers. All other clinical rotations are located in extramural practice sites which include solo, group, and clinical practices scattered throughout the state.

Practicing physicians provide the educational support for the clinical year of training. Students will ideally be responsible for their own learning,

Doctor Wilson is the Director of the Clinical Associate Program at the University of Kentucky Medical Center, Lexington.

but defining the educational content and instructional methods requires thoughtful preparation.

Full-time faculty members from the University are unable to define realistic educational objectives for extramural training sites without the help of practicing physicians. At present, we are in the process of identifying learning opportunities at each extramural location. Emphasis is placed on the most frequently encountered problems of primary care seen in family practice. Students assist by keeping a diary of patient problems that they encounter during evaluations. Practitioners, as extramural instructors, can judge if learning goals are realistic and how learning is to be achieved. Collaboration between program instructors, students, and extramural teachers allows educational development as teachers learn to identify student and program weaknesses and strengths. Preceptors and program instructors should often confer to design the optimum opportunity for students and to identify those in need of special help. Ultimately, practicing physicians learn educational lore, review of basic pathophysiology, and much more. Program instructors are led to discern program weaknesses and strengths and see more clearly the purposes in basic and clinical training.

Physicians in practice who participate in teaching students invest time that they can ill afford, but do have the challenge of clarifying many concepts useful to medical practice and medical care. Teaching is worthwhile and affords continuing education for which credit may be earned toward American Medical Association and American Academy of Family Physicians requirements.

An important secondary purpose of extramural learning is to allow the student to become adjusted to real medical care problems and to learn realistic solutions.

Phase II lasts 11 months followed by Phase III —perceptorships in family practice sites throughout Kentucky. They include either one 12-week period in one practice or two six-week periods in separate sites. This period serves as a final brushing-up and support period before graduation.

Extramural clinical learning during the Phase II and III training periods also helps to reach the objective of providing assistance to medical care throughout the state in areas of need. Physicians in practice who serve in training students not only give valuable curriculum support but during the process participate in judging the worth of the physician's assistant concept and help to judge its utility. Of course, some of the practitioners become employers of program graduates.

Student Selection

To be considered for acceptance into the training program, students must be from Kentucky, have good academic records, and have at least enough experience in patient care to understand health and medical care processes. About 65% of our graduates and students have college degrees at the baccalaureate level and the remainder average two years of college education. Because of these realities it may be reasonable in the future to require all candidates to bring with them at least 60 hours of college credit for admission.

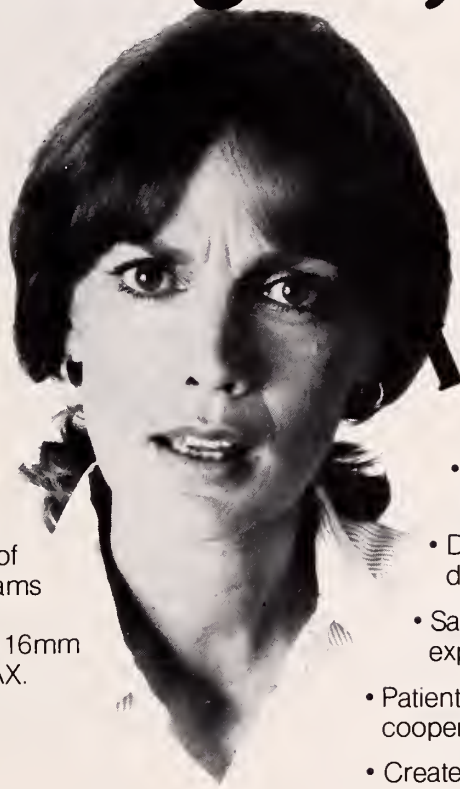
The Outlook

Future plans include increased liaison between program faculty and extramural teachers in practice. Instructors from the University of Kentucky have recently doubled the number of visits to students at learning sites around the state. Meetings are planned to bring together full-time faculty and precepting physicians who have participated in advisory and educational activities with the University. Ideas relating to methods of practical clinical learning and evaluation, student and community relationships, and innovation in education for health care will be subjects for discussion.

Further, this year for the first time, the University program has begun a three-year project in which graduates are visited at their practice sites and interviews are carried out with them and their employing physicians. This study will provide the program with feedback regarding attainment of program goals related to educational content and outcomes.

University program faculty members are well aware of their indebtedness to practicing physicians for their participation and constructive critique of the effort to sensitively educate useful new members in the health care field. Innovations in medical and health care which produce clinicians to serve with physicians will only succeed through participation and approval of practicing physicians.

"I still don't understand. Can you explain it again, Doctor?"



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Report on the 1978 Session of the Kentucky General Assembly

Over 1,300 bills and resolutions were introduced into the 60-day session of the Kentucky General Assembly, which adjourned on March 18. Many of these proposals related to medicine and health and were of interest to KMA.

All proposals were carefully screened and studied by KMA's Legal Counsel, the Chairman and members of the Committee on State Legislative Activities, the Quick Action Committee, and staff. Of the 1,300 bills and resolutions introduced, KMA's interest focused on 126. The Quick Action Committee met weekly during the session, and the full Committee on State Legislative Activities met twice during the session to monitor legislation and develop strategy and positions.

KMA Priority Legislation Passed

KMA strongly supported two pieces of legislation that were of top priority, and both passed.

House Bill 555, Revisions to the Medical Practice Act, was sponsored by Representative John E. Trevey, M.D. This bill strengthens the authority of the State Board of Medical Licensure.

Senate Bill 255, Confidentiality of Peer Review, was sponsored by Senator Joe Prather. This legislation exempts from personal liability those serving on medical peer review committees and exempts records of review committee meetings from subpoena or discovery.

Executive Budget

Included in the Governor's budget are two areas of primary interest to physicians:

(1) Federal monies for Medicaid are decreasing for the State because Kentucky's per capita income is rising and the State is being asked to assume more of this expense. The Governor's Budget takes this into consideration and also includes specific increases in reimbursement to physicians. Beginning in fiscal year 1978-79, physicians will receive 100% of the first $50 for inpatient services per line item of a bill and 65% of allowable charges over $50. In fiscal year 1979, 70% of charges above $50 will be paid. The current rate is 62%.

(2) Approximately $6.5 million has been appropriated for:

a. reimbursement to tertiary perinatal care centers for severely ill newborns whose parents are unable to pay for the care.

b. development of regionalized perinatal services in area hospitals.

A special ceremony was held on Tuesday, March 21, for the signing of HB 555 and SB 255 by Governor Julian M. Carroll. Other participants in the ceremony were (l to r) James B. Holloway, Jr., M.D., Chairman of the KMA Board of Trustees; Don R. Chasteen, KMA Director of Public Affairs; Russell Hester, KHA President; William Conn, KHA Executive Director; Senator Joe Prather; and Mike Wooden, KHA staff.

c. reimbursement for intermediate perinatal care where parents are unable to pay.

Other Bills KMA Supported that Passed

SB 109, Creates the Office of Medical Services, with a physician as the Chief Medical Officer of the Commonwealth.

SB 166, Exempts medical laboratories operated by a physician or group of physicians, solely for the diagnosis and treatment of their patients, from the Medical Laboratory Act. (also accomplished by the passage of the Revisor of Statutes Bill, HB 607)

SB 200, Changes the definitions of "podiatry" and "podiatrist" to conform with those recommended by the American Podiatry Association.

SJR 19, Creates a Commission to study the problems of diabetics in Kentucky.

SR 12, Declares support for giving top priority in the 1978-80 Executive Budget to a 58-bed neonatal unit at the University of Kentucky Medical Center.

HB 86, Creates a Board of Athletic Therapists and provides for certification under the State Board of Medical Licensure.

HB 101, Authorizes the State Board of Medical

Licensure to certify paramedics, separately from the DHR Certification of EMT's. Prohibits any person from holding himself out as a certified emergency medical technician unless he is certified by the DHR.

HB 186, Establishes a program to obtain information about the Sudden Infant Death Syndrome.

HB 318, Updates the Nurse Practice Act.

HB 651, Permits the use of copies of medical charts or records in a trial or other judicial action rather than requiring the Medical Records Custodian to be present.

Bills Opposed by KMA that Passed

SB 94, Grants the Department for Human Resources control of radioactive materials and wastes including new authority to levy fees for licensing and monitoring the users of radiation producing machines and radioactive materials.

SB 209, the "Drop Bill," permits optometrists to use diagnostic drugs excluding drugs classified as controlled substances; permits miotics for emergency use; requires application of such agents only if part of an eye examination and includes optometrists under the Food, Drug and Cosmetic Act. Several unsuccessful attempts were made to limit the drugs used by optometrists to "paradrine" and "ophthaine."

HB 11, Allows payment for chiropractic services under the Kentucky Workmen's Compensation Program. Kentucky is the last state to include chiropractors under its Workmen's Compensation provisions.

HB 497, Requires hospitals that offer emergency services to have a physician on call 24 hours each day for examination of reported victims of sexual offenses.

Bills Opposed by KMA that Failed to Pass

SB 5, Would have amended the statutes on medical education loans and scholarships to alleviate a shortage and maldistribution of physicians in primary care practice with a triple penalty for non-compliance of practice for each year of loan.

SB 53, Would have required each health care professional licensing agency to collect information on licensees as a prerequisite for license issuance or renewal.

SB 54, Would have required medical school applicants to agree to practice in Kentucky one year for each year of schooling or repay the cost to the State of their medical education.

SB 55, Would have placed a representative from each Area Development District on each medical school admissions committee to provide for more rural representation.

SB 56, Would have established a system of primary health care centers staffed by paraprofessionals in rural, medically-underserved areas.

HB 19, Would have required the State Board of Medical Licensure to issue regular licenses to graduates of foreign medical schools (Foreign medical school graduates can already obtain a regular license in Kentucky by passing the same examination as American graduates).

HB 20, Would have created a Health Services Cost Review Commission.

HB 59, Would have removed the protective headgear requirement for motorcyclists.

HB 70, Would have legalized the sale and distribution of laetrile.

HB 118, Would have required state schools of medicine, dentistry, and law to allocate 70% of entering enrollment positions equally among the Kentucky Congressional Districts; would have allocated 15% of remaining positions to Kentucky residents at large and would have required non-resident positions to not exceed 15%. Provisions of this bill were piggybacked on several other bills but failed to pass.

HB 154, Would have prohibited medical practitioners from dispensing, prescribing, administering, distributing, or transferring any amphetamines for use in dieting. (This was opposed because of undue governmental involvement in the prescribing of drugs).

HB 295, Would have permitted graduates of chiropractic colleges seeking accreditation to be eligible for a license to practice.

HB 509, Would have required a practicing physician from each Kentucky Congressional District to sit on the admissions committees at the two universities' medical schools.

HB 566, Would have required that 30% of the

Carl Cooper, Jr., M.D., Chairman of the KMA Committee on State Legislative Activities, presented the report on the 1978 Kentucky General Assembly to the Board of Trustees at its meeting on April 6.

money appropriated to the Rural Kentucky Medical Scholarship Fund be used solely to develop the supply of physicians in underserved areas of counties containing cities of the first and second classes.

HB 721, Would have required the Workmen's Compensation Board to enforce and publish annually a schedule of usual and customary fees for medical services rendered.

HB 765, Would have changed the educational requirements for licensed chiropractors from "graduation from an accredited chiropractic college" to "graduation from one having status with the Commission on Accreditation, or one which meets equivalent standards."

Legislative Wrap-Up

A brief description of the major bills followed by KMA is included for your records. We express our appreciation to the members of the KMA Quick Action Committee, members of the KMA Committee on State Legislative Activities, Legislative Key Men, and all KMA and KEMPAC members who worked so diligently during the 1978 session of the Kentucky General Assembly.

We would suggest that you continue to maintain a friendly rapport with your State Senator and State Representative.

Carl Cooper, Jr., M.D., Chairman
KMA Committee on State Legislative Activities

1978 Kentucky General Assembly Bills Having Health or Medical Interest*

Bill	Description	Action
	ABORTION	
SB 97	Define abortion referral agency; deny fees in such service	Law
SB 218	Expand list of people who cannot be forced to participate in abortion	Died Senate
SCR 11	Ask Congress to amend Constitution to protect unborn	Died Senate
HB 299	Prohibit health insurance coverage of elective abortions except by optional rider	Law
HCR 7	Petition Congress to amend Constitution to prohibit abortions	Law
	ADMINISTRATIVE	
SB 109	Create the Office of Medical Services	Law
HB 607	Revisor's Bill—exempts private physicians' offices from Medical Laboratory Act	Law
	CHILDREN	
HB 18	Require medical exam for foster children	Law
HB 77	Create program to screen, diagnose, and treat children before age 5	Died House
HB 78	Mandatory immunization program prior to school enrollment	Died House
HB 98	Change definition of abused or neglected children; provide for protection and care	Law
HB 198	Require hospitals to allow parents to stay with children	Died House
	DRUGS/HEALTH CARE PRODUCTS	
SB 129	Exempt from sales tax certain ostomy care products	Died Senate
SB 254	Drug labeling by manufacturers	Law

**If you desire information on any legislation not included in this summary, contact the KMA Headquarters Office.*

HB 70	Legalization of Laetrile	Died Senate
HB 154	Prohibit use of amphetamines for dieting	Died Senate
HB 277	Exempt certain prosthetic devices from sales and use tax	Died House
HB 296	Exempt certain ostomy care products from sales tax	Died House

HEALTH

SJR 19	Create commission to study problems of diabetics; $60,000 appropriated	Law
HB 20	Health Services Cost Review Commission	Died House
HB 186	Establish program on SIDS—require autopsy with approval	Law
HB 717	Create Kentucky Cancer Commission and provide for cancer research; $2,000,000 appropriation	Law

LONG-TERM CARE FACILITIES

HB 217	Enumerates rights of residents in long-term facilities; defines such facilities and residents	Law
HB 218	Require DHR to rate quality of care given by long-term facilities	Died House
HB 219	Define long-term facilities; require unannounced inspections	Law

MEDICAL SCHOOLS/SCHOLARSHIPS/CURRICULUM

SB 5	Amend statutes on medical education loans and scholarships	Died Senate
SB 54	Require medical school applicants to agree to practice in state	Died Senate
SB 55	Place representative from each Area Development District on medical school admissions committees	Died Senate
SB 214	Include preventive medicine/public health in definition of primary care residency	Law
SJR 6	Geographical distribution of students admitted to medical schools	Died Senate
HB 118	Require medical, law, dental schools to allocate 70% of admissions among Kentucky Congressional Districts	Died Senate
HB 509	Require practicing physician from each Congressional District on medical school admissions committees	Died House
HB 566	Require 30% of RKMSF funds to go to students in underserved counties with 1st or 2nd class cities	Died House
HJR 61	LRC to study low incidence of admissions of rural Kentuckians to medical, law, dental schools	Law

OCCUPATIONS AND PROFESSIONS

SB 53	Require boards licensing health professionals to collect and transmit health manpower data to DHR	Died Senate
SB 166	Exempt private physicians' offices from Medical Laboratory Act	Law
SB 209	Allow optometrists to use specified drugs	Law
SB 229	Require health insurance companies to pay social workers	Died House
SB 255	Confidentiality of Peer Review	Law
HB 11	Provide payment to chiropractors under Workmen's Compensation	Law
HB 19	Licensing of Foreign Medical Graduates	Died House
HB 53	Audiologists/speech pathologists/hearing aid dealers and fitters	Died Senate
HB 86	Certification of athletic trainers under Board of Medical Licensure	Law
HB 101	Certification of EMT's under DHR/Paramedics under Board of Medical Licensure	Law
HB 102	Physicians' Assistants	Died Senate
HB 318	Nurse Practice Act	Law
HB 393	Permit counties with 30,000 or more population to levy tax on professions	Law
HB 497	Require hospitals offering emergency services to have physicians on call 24 hours for rape cases	Law
HB 555	Medical Practice Act	Law
HB 651	Permit copies of medical records and charts in judicial proceedings	Law
HB 765	Change education requirements for chiropractors	Died House
HCR 117	LRC to review and evaluate need for licensing agencies	Died House

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And more effective than pentobarbital through 28 nights of administration...[3,4]

In an original study designed to evaluate hypnotic effectiveness for 28 consecutive nights of use, the relative ineffectiveness of pentobarbital was established after only two weeks.[3] Dalmane, however, remained effective not only for 14 nights, but for 28 nights in chronic insomniacs,[3,4] without increasing dosage from night to night. Prolonged administration of Dalmane is seldom necessary, but when it is, periodic blood counts and liver and kidney function tests should be performed.

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Specific safety benefits not shared by barbiturate hypnotics: Dalmane (flurazepam HCl) may be used in patients on chronic warfarin therapy; no unacceptable fluctuation in prothrombin time has been reported.[5,6] And Dalmane has been proved not to interfere chemically with many common laboratory tests.[7-9] (Alterations have been reported due to pharmacological effects; see Adverse Reactions section of complete product information.)

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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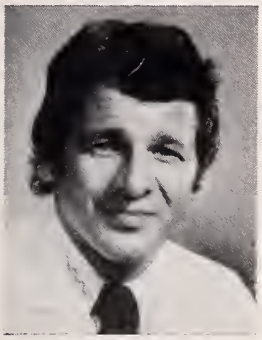
Pages 241-242 and pages

ASSOCIATIONAL NEWS

New Location and Outstanding Scientific Program Are Features Of 1978 KMA Annual Meeting—September 24-28

The 1978 KMA Annual Meeting will be held in all new surroundings—**the Hyatt Regency/Lexington Convention Center**—on September 24-28. However, the same excellent scientific program, informative scientific and technical exhibits, entertaining President's Luncheon, and interesting business sessions, will be featured once again this year.



Doctor Stevens

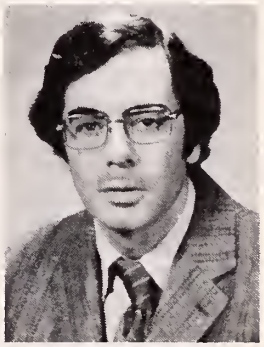
Under the chairmanship of Richard F. Hench, M.D., Lexington, the KMA Scientific Program Committee has been working since November to design this year's program so 19 medical specialties are represented. A wide range of medical topics, to include pulmonary disease, endocrinology, and colonoscopy, will be discussed by many prominent guest speakers from Kentucky and throughout the nation during the three-day session.

The opening speaker on Tuesday, September 26, Paul M. Stevens, M.D., Houston, will discuss "A Simplified Approach to the Assessment and Management of Acute Respiratory Failure." Doctor Stevens is Professor of Medicine and Chief of the Pulmonary Section at Baylor College of Medicine and The Methodist Hospital. A recipient of numerous medical teaching awards, Doctor Stevens is a Fellow of the American College of Physicians, and belongs to the American Thoracic Society and the American Federation of Clinical Research.

Joseph E. Davis, M.D., New York, will speak Wednesday morning, September 27, on "A Rational Approach to the Treatment of Cancer of the Prostate." Doctor Davis is Professor and Chairman of the Department of Urology at New York Medical College. A Fellow of the American College of Surgeons, he belongs to the American Fertility Society, the American Urological Association, and the International College of Surgeons. He is Past President of the Association for Voluntary Sterilization.

Speaking on "The Importance of Cardiovascular and Renal Prostaglandins," on Wednesday afternoon, will be Michael J. Dunn, M.D., Cleveland. Doctor Dunn is the Hanna Payne Professor of Experimental Medicine and Director of the Division of Nephrology at Case Western Reserve University College of Medicine. A member of the American and International Society of Nephrology,

Doctor Davis



Doctor Dunn

Doctor Dunn is a Fellow of the American College of Physicians.

In addition to the four general scientific sessions and 19 specialty group meetings, the KMA House of Delegates will meet on two occasions (September 25 and 27) and the President's Luncheon will be held on September 27.

Further details on other speakers and highlights of the 1978 KMA Annual Meeting will be published in upcoming issues of *The Journal* and "Communicator."

KMA Insurance Agency Board Elects Officers, Staff

The Board of Directors of the KMA Insurance Agency, Inc., held its organizational meeting on April 6, 1978, at the KMA Headquarters Office. The Agency's Board is composed of the members of the KMA Board of Trustees; Robert G. Cox, KMA Executive Vice President; David L. Rader, Vice President of the Physicians Insurance Company of Ohio (PICO); Lolita S. Weakley, M.D.; and Carl L. Wedekind, Jr., Legal Counsel.

Election of officers of the Corporation was as follows:

Chairman of the Board	**Ballard W. Cassady, M.D.**
President	**John P. Stewart, M.D.**
Vice Presidents	**James B. Holloway, Jr., M.D.**
	Carl Cooper, Jr., M.D.
	S. Randolph Scheen, M.D.
Secretary-Treasurer	**Robert G. Cox**

Eight members of the Board were elected to serve on the Executive Committee until the annual meeting of the Board of Directors following the annual stockholders meeting: Ballard W. Cassady, M.D., Chairman; John P. Stewart, M.D.; James B. Holloway, Jr., M.D., Carl

Cooper, Jr., M.D.; S. Randolph Scheen, M.D.; Robert G. Cox; Carl L. Wedekind, Jr.; and David L. Rader.

The organizational meeting was the first step toward the formation of a physician-owned insurance company in Kentucky. The Agency will be in a position within a short time to begin selling through PICO both primary and excess professional liability insurance coverage on an occurrence basis.

Douglas J. Freeman of PICO has been named General Manager of the Agency and Shirley A. Roessler of the KMA staff is the Assistant Manager. Trustee Districts are holding meetings throughout the state with the purpose of providing the membership with some vital and current information on the present status of the Agency.

Further information will be forthcoming through membership mailings, the "Communicator," and future issues of *The Journal.*

Informative Program Planned For Emergency Care Seminar, June 7-9

KMA and the Commonwealth of Kentucky will combine their efforts this year to present the Eighth Emergency Medical Care Seminar and the Third Emergency Medical Services Conference on June 7-9 at the Executive West in Louisville.

Over 500 health professionals are expected to attend the Seminar, which will memoralize William J. Carey, M.D., an active member of the Emergency Medical Care Committee who died in January of this year.

John D. Hoyle, Administrator of St. Luke Hospital in Ft. Thomas, will be the luncheon speaker on June 7. Mr. Hoyle, who has a long-time interest in emergency medical services and disaster planning, will talk from first-hand experience on "The Beverly Hills Disaster—Implications for Medical Disaster Planning." A former Vice-President of the Kentucky Hospital Association, Mr. Hoyle is a recipient of the Pfizer Award of Merit for his emergency medical contributions.

Mr. Hoyle

The scientific program, which follows this article, will also include a CPR workshop for certification in Basic Life Support. This course, which is already filled, will be held Wednesday and Thursday afternoons, with a re-certification workshop scheduled for Thursday at 2:30 p.m. Registration is still available for this program.

Continuing medical education credit can be obtained from the American Medical Association (hour per hour basis toward the Physician's Recognition Award) and the American Academy of Family Physicians (10 hours). Application for credit has also been made with the Kentucky Chapter, American College of Emergency Physicians, Kentucky Dental Association, Emergency Department Nurses Association, National Registry of Emergency Medical Technicians, and Kentucky State Association of Licensed Practical Nurses.

Further details of the program and registration (fee of $15 per day) may be obtained from the KMA Headquarters Office. A program outline for the Seminar follows:

KMA Emergency Medical Care Seminar and Commonwealth of Kentucky Emergency Medical Services Conference

WEDNESDAY, JUNE 7

Morning Session

Registration—8:00 a.m.

"Dilemmas"

"The Rejected Patient with Abdominal Pain"—Hal Houston, M.D.
"Failure of Packing Nose Bleeds"—Gorden T. McMurry, M.D.
"The Winter of '78 (Little Blue Toes)"—John G. Stansbury, M.D.
"Forced Air High Pressure Injuries"—Graham Lister, M.D.
"Temporomandibular Joint Pain"—Robert D. Marciani, M.D.
Panel Discussion
Noon Luncheon: *"The Beverly Hills Disaster—Implications for Medical Disaster Planning"*—John D. Hoyle

Afternoon Session

"Dilemmas of Electrocardiographic Interpretation Under Duress"—Henry W. Post, M.D.
"Triage by Telephone"
"Thermal Injuries"—Phillip Blevins, M.D.
"Carbon Monoxide Inhalation"—Donald Thomas, M.D.
"You Asked for It—You've Got It"—Lafayette G. Owen, M.D.
"Pre-cordial Thump and the Epigastric Squeeze"—June Willis, C.C.R.N.
Panel Discussion

THURSDAY, JUNE 8

Morning Session

Registration—8:00 a.m.

"The High Risk Newborn"

"Physiologic Defects"—Larry Cook, M.D.
"Predisposing Factors of Childbirth"—Terrell Mays, M.D.
"High Risk Infant Transport"—Roger J. Shott, M.D.
"Communication"—Jo Ann Cannon, R.N.
"Problems in Transportation"—Randy Herron
"Tertiary Care Unit"
"Political Economic Factors"
Noon Luncheon

Afternoon Session

Concurrent Specialty Workshops:
- Kentucky Coordinators Association
- Kentucky EMT Association
- Emergency Department Nurses Association
- American College of Emergency Physicians
- University of Kentucky College of Dentistry
- CPR Workshops (Basic Life Support and Recertification in BLS)

FRIDAY, JUNE 9

Morning Session

"EMS Overview—Progress of the Past and Challenges for the Future"—Roland Dallaire

"Establishing a Poison Control Center"—Pamela Ford, R.N., P.H.N.

"Maternal/Infant Transport—Key to Regionalization"—Evelyn H. Melnik, M.D.

"Rural EMS—A Systems Approach"—John Farquar, M.D.

Luncheon—Conference Re-Cap

Insurance Co. Is Main Topic At Ten Trustee Meetings

Ten Trustee Districts have held or have scheduled meetings during April, May, and June for the main purpose of providing information to the membership on the status of the KMA professional liability insurance company.

Representatives from KMA and PICO (Physicians Insurance Company of Ohio) have been in attendance at the District meetings to report on current activities and to answer questions regarding the new physician-owned company.

Those Districts meeting during 1978 are:

Date	District	Trustee
April 17	Fifth	Cecil L. Grumbles, M.D.
April 20	Fourth	Charles B. Spalding, M.D.
May 2	Thirteenth	Howard B. McWhorter, M.D.
May 9	Tenth	James B. Hallaway, Jr., M.D.
May 16	Fourteenth	Harvey A. Page, M.D.
May 17	Eleventh	Dwight L. Blackburn, M.D.
May 23	Second	R. J. Phillips, M.D.
May 25	Seventh	William H. Keller, M.D.
June 6	Sixth	Earl P. Oliver, M.D.
June 8	First	Wally O. Montgomery, M.D.

Did you know . . .

Officers and staff attended the AMA Regional Meeting in Atlanta on April 5 where they were briefed on the current status of the voluntary hospital cost containment effort being supported by the AMA, AHA, and Federation of American Hospitals. AMA's recommended guidelines on controlling health care costs were also reviewed.

The Administration sent a bill to Congress that would overhaul prescription drug laws. The Drug Regulation Reform Act of 1978 would establish a monograph system for drug approval, give extensive controls over the distribution and dispensing of drugs to the HEW Secretary, and require patient information labeling for most drugs. The AMA is developing amendments to the present law that would speed up the introduction of safe and effective drugs, provide an optional procedure for the new drug approval process, and provide for patient information leaflets under certain conditions.

* * *

HEW spent $14,000 to prepare the original list of physicians who supposedly received $100,000 from Medicare in 1975 and then spent $122,000 to correct the list, according to the General Accounting Office. The GAO also said the listing was "poorly managed," full of mistakes, prematurely released, and expensive. The AMA had found the list to be about 65% inaccurate.

Trustees' Report

SECOND TRUSTEE DISTRICT

R. J. Phillips, Jr., M.D., Owensboro

Details of the new KMA insurance company will be considered at the Second Trustee District meeting to be held in Owensboro on May 23rd. Information will be available on the new KMA insurance agency and stock for the company. The malpractice insurance policy will have features different from those previously available. Clearance by the state insurance commission is expected so that the new policies will be available in June.

Members in the news

NEW MEMBERS

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Hooshang Silanee, M.D., Highland Heights
Mehdi Zargarzadeh, M.D., Highland Heights

FAYETTE

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Alan K. David, M.D., Lexington
George F. Hatch, Jr., M.D., Lexington
Willard B. Olmstead, M.D., Lexington
M. D. Ram, M.D., Lexington
John W. Walsh, M.D., Lexington
Hal T. Wilson, M.D., Lexington

GRAVES

Daniel Beineke, M.D., Mayfield

GREENUP

David H. Proctor, M.D., South Shore

JEFFERSON
Richard A. Eiferman, M.D., Louisville
Michael Faurest, M.D., Louisville
Laurence F. Perlstein, M.D., Louisville
John F. Rice, M.D., Louisville
Bernard T. Moynahan, III, M.D., Louisville

LOGAN
Jitemdra A. Pathak, M.D., Russellville
Kunja Pathak, M.D., Russellville

NELSON
James A. Hedrick, M.D., Bardstown

OLDHAM
Thomas Clark, D.M.D., Pewee Valley

PENNYRILE
Thelma S. Manlavi, M.D., Hopkinsville

PERRY
I. N. Nayak, M.D., Hazard
Donnie R. Spencer, M.D., Hazard

PIKE
Rene Joyeuse, M.D., South Williamson

TRIMBLE
Charles H. Hood, M.D., Bedford

WHITLEY
Bernard C. Moses, M.D., Williamsburg

THOSE HONORED

Paul J. Parks, M.D., Bowling Green, was recently named Chairman of the Board of Trustees at Georgetown College. Doctor Parks, an internist, is the Immediate Past President of KMA and is a 1943 graduate of Georgetown College.

Danielle Turns, M.D., Louisville, was appointed State Director of Kentucky by the American Medical Women's Association. Doctor Turns is Associate Professor of Psychiatry at the University of Louisville School of Medicine.

Headquarters Activity

APRIL

5	AMA Regional Meeting, Atlanta Executive Committee, Louisville
6	Board of Trustees, Louisville KMA Insurance Agency Board of Directors, Louisville
10	*Journal* Editors, Louisville
10-11	Sports Symposium, Lexington
12	Committee on Occupational Health and Environmental Quality, Louisville
13	Joint Practice Committee, Louisville
16-22	AAMSE Advisory Committee to Study National Health System, Toronto, Canada
17	Jefferson County Medical Society Meeting, Louisville
20	Membership and Placement Services Committee, Louisville Advisory Committee to Blue Cross and Blue Shield, Louisville Fourth Trustee District, Bardstown
25-26	Resident's Workshop, Louisville
26	Judicial Council, Louisville
27	Blue Cross-Blue Shield Board Meeting, Louisville
28	Interspecialty Council, Louisville

MAY

2	Thirteenth Trustee District, Ashland
4	Committee on Community and Rural Health, Louisville
8-10	Kentucky Hospital Association Annual Meeting, Louisville
9	Tenth Trustee District, Lexington
9-13	Kentucky Chapter, American Academy of Family Physicians Annual Meeting, Louisville
15	*Journal* Editors, Louisville
16	Fourteenth Trustee District, Pikeville
17	Eleventh Trustee District, Richmond
18	Rural Kentucky Medical Scholarship Fund Board of Trustees, Louisville
22-23	Washington Dinner, Washington, D.C.
23	Second Trustee District, Owensboro
24	Cancer Committee, Louisville
25	Seventh Trustee District, Frankfort

ANNUAL MEETING REMINDERS

The deadline for applying for space for a **scientific exhibit** at the 1978 KMA Annual Meeting is July 1. Physicians interested in presenting an exhibit should have their applications in by that time, according to Richard A. Kielar, M.D., Chairman, KMA Scientific Exhibits Committee. An application for space appeared in the March issue of *The Journal* on page 124 or may be obtained from the KMA Headquarters Office.

* * *

The **Awards** Committee is accepting nominations for the Kentucky Medical Association Award and the Distinguished Service Award, according to Fred C. Rainey, M.D., Awards Committee Chairman. The awards are presented annually at the President's Luncheon during the KMA Annual Meeting.

LOOKING AHEAD

June 17-22 A
September 24-
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October 14 R
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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THE MESSAGE OF TENSION

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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15th .... HAROLD L. BUSHEY, 406 Knox St., Barbourville 40906—606/546-3024 1978

JUNE BUYERS GUIDE FOR JOURNAL OF KMA

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MESSAGE FROM THE PRESIDENT

June Will Be A Busy Month At KMA

As we come out of a severe winter into a rainy spring and hopefully into a sunny summer, we find the first month of summer at the KMA will be a busy one. A number of important activities are scheduled. Some of these are new activities at KMA and others are annual affairs which are organized and supported by our members. We look forward to a very busy and active month in June and feel that at the end of the month we will be able to look back and be well satisfied with our accomplishments.

First of all, as of June 1, the KMA Insurance Agency and the Physicians' Insurance Company of Ohio will be prepared to begin selling insurance as set up by our Kentucky Insurance Agency. A number of Trustee District meetings will have been held prior to June 1 in preparation for offering both primary and excess professional liability coverage to our members. We feel that this will be an excellent service to our members, and with our membership support I feel this will be a very important step towards resolving our past problems in malpractice insurance.

The Eighth Annual KMA Emergency Medical Care Seminar will be held in conjunction with the Third Annual State EMS Conference June 7-8-9 at the Executive West in Louisville. This program has been well accepted and very well attended each year. This seminar requires a great deal of work by our staff to put together and is aided by participation of our KMA physicians in giving the lectures for this program. This has always been extremely well received and is an important part of our continuing medical education at KMA.

Also in June is the Washington Dinner, which is an annual affair and gives us the opportunity to meet with our representatives in Congress. This has been a very informative and useful affair and one in which your KMA leadership has an opportunity to discuss face-to-face the issues, which are of primary concern in medicine, with our Congressional representatives. We hope to inform our representatives of our feelings regarding health care programs which might be of the best interest for the purpose of providing good health care for the citizens of the Commonwealth of Kentucky, as well as of the United States.

Finally I want to remind you that the Annual Meeting of the American Medical Association is being held June 17-22 in St. Louis, Missouri. We are fortunate again in having a candidate for the President-Elect of the American Medical Association, Doctor H. D. Gardner of Louisville. I know all of our members will give every effort in Doctor Gardner's behalf and I feel that when the meeting is over, Doctor Gardner will be the new President-Elect of the American Medical Association. This will require our active participation and you are urged to participate as much as you possibly can in the campaign activities.

Please give your support to all of the above programs and while there is a lot of hard work ahead for this month we feel that it will be carried to a successful completion.

S. Randolph Scheen, M.D.
KMA Secretary-Treasurer

This is the fourth in a series of articles written at the request of KMA President John P. Stewart, M.D.

A Link in the Chain

Auxiliary

Mrs. Charles Nicholson, Lexington, was installed as President of the Auxiliary to KMA at its Annual Convention, April 25-26. She will write the "A Link in the Chain" page for The Journal during the 1978-79 Auxiliary year.

Mrs. Nicholson

The Challenge of Change: The Challenge of Growth

TO change is always a challenge. Hopefully, along with change will come growth. We have already met one challenge by changing our Annual Convention from fall to spring. The state Auxiliary has long felt out of step with the county auxiliaries and the national auxiliary. Now we are all three beginning together, planning together, learning together, and growing together.

We have another large change coming this fall. The KMA convention will be in Lexington, as will our Fall Board meeting. There is excitement around the state about coming to a new Kentucky facility. We in Lexington are very eager to show it to you.

While we are looking at the state Auxiliary, trying to implement several changes within our committees, programs and leadership training, do we need to look at the counties? Do the counties need any changes; do they need to grow? It is much easier to continue year after year what has always been done than to attempt a change. Join with the state Auxiliary and attempt a few changes.

"Bloom Where You Are Planted!" You are planted in a marvelous state for growth. Perhaps your first peek at Kentucky came when you and your husband planted yourselves here. Through you and through your medical auxiliary your community will also bloom and grow.

I would like to challenge you to change, if you find there is a need. I would like to challenge you to grow, if you find there is a need. It will be my pleasure and honor to grow with you this year.

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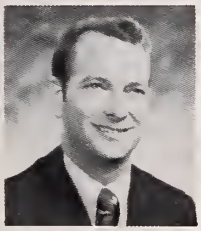
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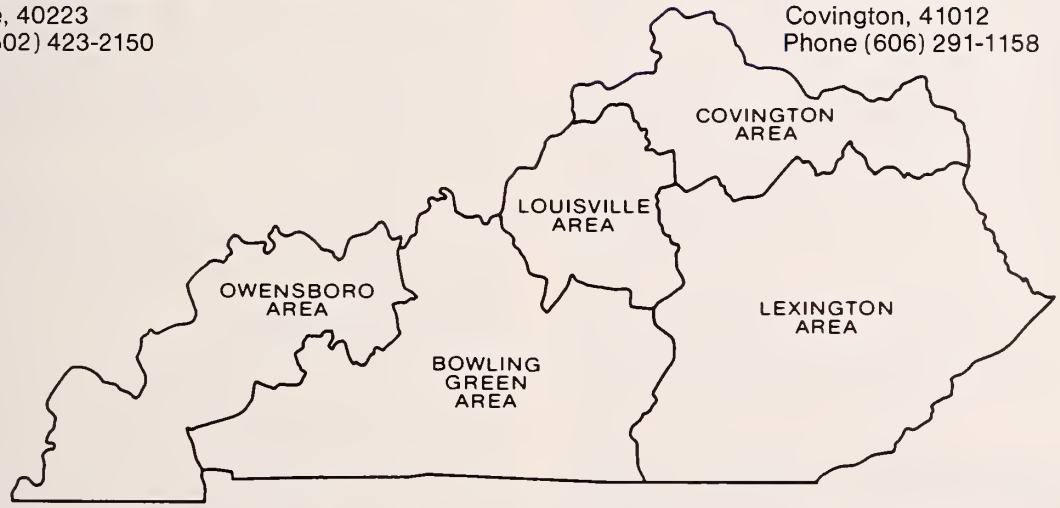

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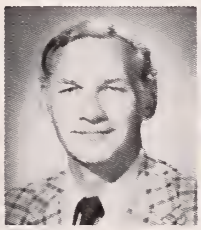
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In an original study designed to evaluate hypnotic effectiveness for 28 consecutive nights of use, the relative ineffectiveness of pentobarbital was established after only two weeks.[3] Dalmane, however, remained effective not only for 14 nights, but for 28 nights in chronic insomniacs,[3,4] without increasing dosage from night to night. Prolonged administration of Dalmane is seldom necessary, but when it is, periodic blood counts and liver and kidney function tests should be performed.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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JUNE

14 "Update on Renal Transplants**," Louisville Area CME Consortium, Jewish Hospital, Louisville

24 Cancer Update in the Parks, "Skin Cancer," Kentucky Division, ACS, Jenny Wiley State Resort Park

28 "Estrogen and Progestational Steroids in the Female**," Louisville Area CME Consortium, Health Sciences Center, Louisville

JULY

24-28 Topics in Maternal/Fetal Medicine, University of Louisville Department of Ob/Gyn, Louisville

AUGUST

23 "Common Athletic Injuries**," Louisville CME Consortium, Suburban Hospital, Louisville

SEPTEMBER

21-23 "Gynecologic Surgery," University of Louisville Department of Ob/Gyn, Louisville

24-28 KMA Annual Meeting, Hyatt Regency/Lexington Convention Center, Lexington

IN SURROUNDING STATES

SEPTEMBER

11-12 Tennessee Valley Medical Assembly, Chattanooga Choo Choo Convention and Concert Hall, Chattanooga, Tennessee. Contact: Jerome H. Abramson, M.D., Chairman, 960 E. 3rd St., Suite 313, Chattanooga, Tennessee 37403

***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

Ninth Family Medicine Review

Session I: June 25-30
Session II: August 13-18
Session III: December 10-15
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State to Sponsor Program On Alcohol, July 16-21

The Eighth Annual Kentucky School of Alcohol Studies will be held July 16-21 at Centre College, Danville, Kentucky. There will be six general sessions and approximately 25 workshops, covering such topics as: Family Counseling, Group Dynamics, Role of the Clergy, Alcohol Problems in Minority Populations, Youth, Management Skills, Criminal Justice System, Relaxation Therapy, Medical Complications, and Business/Industry.

The Honorable Wilbur D. Mills, former United States Congressman, will be the keynote speaker for the Banquet on July 16. For registration information, contact the Kentucky School of Alcohol Studies, Department for Human Resources, Bureau for Health Services, Alcohol Section, 275 E. Main St., Frankfort, Ky. 40601 or call (502) 564-7450.

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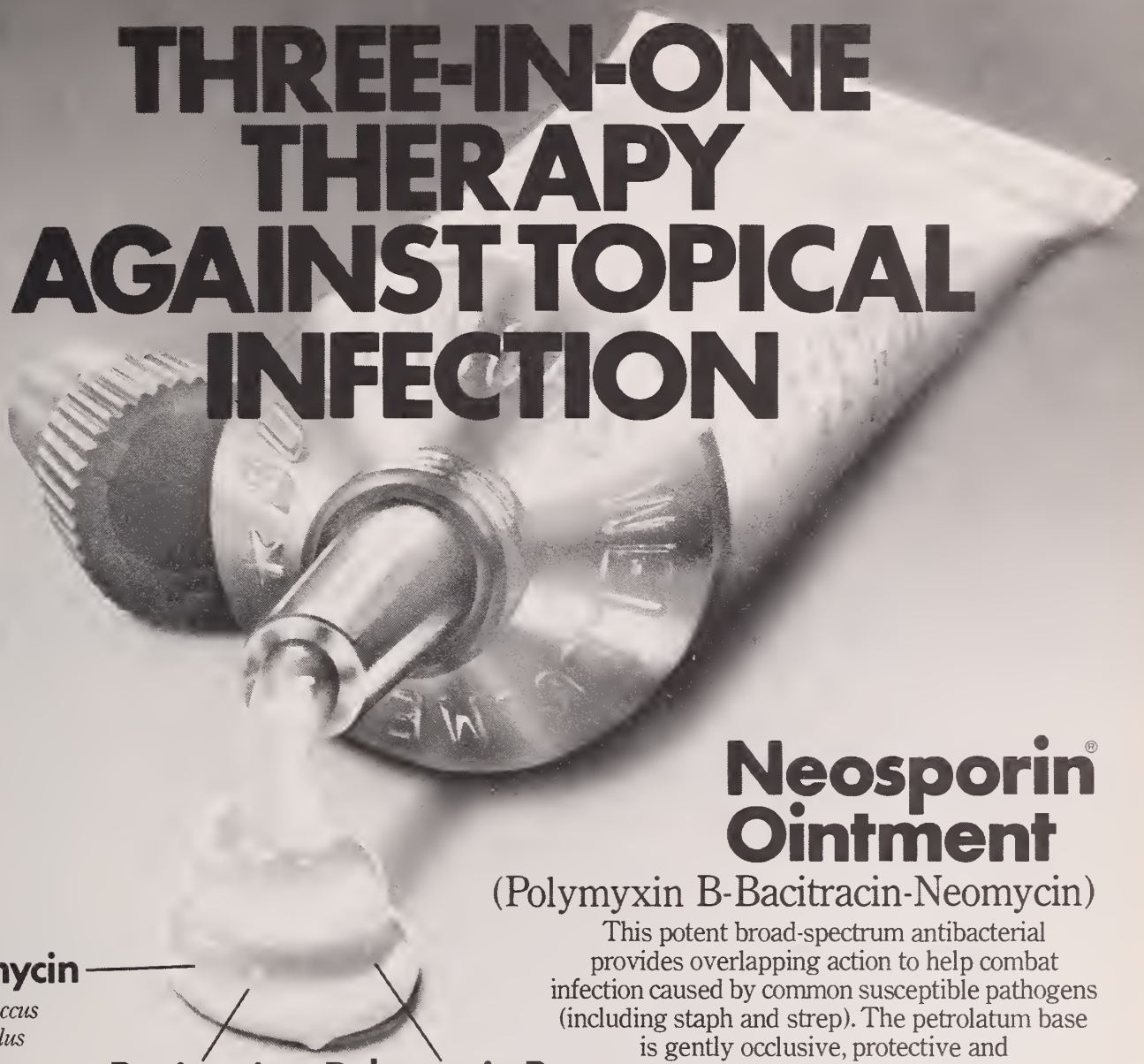

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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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The JOURNAL of the
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VOLUME 76 JUNE 1978 NUMBER 6

Exercise Induced Asthma

David H. Winslow, M.D.

Louisville, Kentucky

Increased awareness of exercise induced asthma, especially in asthmatics or patients with allergic histories, can lead to proper diagnosis and treatment. Two case reports illustrate that diagnosis is simple and that treatment can be beneficial.

MOST patients with exercise induced asthma (EIA) will never be diagnosed unless the primary physician recognizes its possibility and suggests appropriate pulmonary function testing. Since the therapy is so often rewarding, all patients with asthma, exercise induced symptoms, or allergic histories should be suspect. A high percentage of these patients will have a positive test for EIA.

Case Reports

Case #1. W.C. is a 20-year-old black male who had had a history of nonseasonal asthma without rhinitis from childhood. He had been followed in the allergy clinic at Children's Hospital until age 15 and had been on an allergy desensitization program. From age 15 he had been treated by his family physician with various medications, which included Tedral®, antihistamines, periodic injections of steroids, and inhalations of isoproterenol.

The patient had participated in high school and college level basketball. He noticed a tendency to get short of breath about five to ten minutes after beginning exercise and that this tended to get worse if he sat down to rest. He had used isoproterenol to help relieve exercise induced symptoms with partial success. Pre- and post-exercise pulmonary function studies were performed. The level of exercise was 3 mph, at 10% grade for six minutes. Post-exercise wheezing was marked at ten minutes. At 15 minutes post-exercise, forced expiratory volume in one second ($FEV_{1.0}$) had declined by 33%. The forced expiratory flow between 25-50% of vital capacity (FEF_{25-50}) and the forced expiratory flow at 75-85% of vital capacity (FEF_{75-85}) decreased by 50%.

One week later, exercise pulmonary functions were done following inhalations of cromolyn just prior to exercise. There was no post-exercise wheezing. $FEV_{1.0}$ declined by only 13%.

The patient reported much greater exercise tolerance and was maintained on cromolyn and terbutaline daily, timing the doses so that one 5 mg tablet of terbutaline was given one hour before and cromolyn immediately before practice and games.

Case #2. L.W. is a 16-year-old white male with a history of asthma since age three. From age three to about age ten he had intermittent attacks of asthma requiring visits to the emergency room or doctor's office. There was no apparent seasonal variation or allergic rhinitis. The patient was given a series of allergy shots during this period and was treated with Maarax®. The asthma improved each year and by age 12 he had infrequent attacks of asthma, but noticed that he had wheezing when he ran in the school yard.

From the Division of Respiratory and Environmental Medicine, Department of Medicine, University of Louisville School of Medicine, Louisville.
Received at KMA: 3-9-78.

By the seventh and eighth grades attempts to participate on the track team were hampered by post-exercise wheezing. Although swimming caused less problems, competitive swimming in the tenth grade was also made very difficult by post-exercise wheezing. In 1976 pre- and post-exercise pulmonary function studies were done. He had marked post-exercise wheezing, and the $FEV_{1.0}$ and the FEF_{25-50} decreased by 50% and 46% respectively. After a two hour rest cromolyn was given by inhalation and the tests were repeated with no post-exercise wheezing and no drop from baseline pulmonary functions.

Follow-up history reveals that on cromolyn prophylaxis and a metaproterenol inhaler for acute attacks, the patient has had no exercise induced shortness of breath and now participates regularly in basketball, hiking, and tennis.

Methods

Within the past year we have tested 20 patients with a history of shortness of breath, after exercise felt to be related to exertional asthma. The patients' ages ranged from 10 to 23; 16 were male and 4 were female. Seventeen patients had a definite history compatible with asthma. Of the patients sent by referring physicians, 16 had post-exercise wheezing, significant decrease in pulmonary functions greater than 15% or both. Four of the 16 patients had decrease in pulmonary functions less than 15%, but had post-exercise wheezing. The level of treadmill exercise we have used has been 10% elevation at 3 mph for six minutes.

This approach, which has been previously outlined by Godfrey,[1] has been shown to induce bronchospasm in most patients who are susceptible. Also, these results have been shown to be reproducible if successive tests are given not closer than two hours in the same day. One child, age ten, was unable to perform pulmonary function tests properly, but did have post-exercise wheezing. Treatment with B-adrenergic bronchodilators was occasionally needed post-exercise for relief of exercise bronchospasm. Five patients had their response to exercise blocked when the test was repeated two hours later with pre-exercise inhalations of cromolyn. Seven patients in a separate clinical study had the response modified with inhalations of atropine.

Discussion

Exercise induced bronchospasm occurs in all ages but is more common in the younger age group. About 90% of asthmatic children will have a decrease in peak expiratory flow rate of greater than 10% when tested, but anyone who has wheezing after exercise should be considered to have EIA.[2] It is especially common in severe asthmatics, occurring in approximately 85-90% of boys and 65% of girls, and occurs in about 35-40% of patients with hay fever or eczema, despite the fact that a history of exercise associated wheezing may be absent in a significant number.[3]

Godfrey[1] has shown that changes in EIA consist of an initial period of bronchodilation during the first two to four minutes of exercise,

Table 1
SUGGESTED DRUG DOSAGES FOR EIA

Drug	Dosage	Route of Administration	Time of Administration Prior to Exercise	Accepted for International Competition	Accepted for NCAA Competition
Cromolyn sodium	20 mg	Inhalation	1 to 15 min	Yes	Yes
Terbutaline	5 mg (12+ yr)	Orally	1 hr	Yes*	Yes
Metaproterenol	20 mg (12+ yr)	Orally	1 hr	No	Yes
Metaproterenol	1.3 mg	2 Inhalations	No	No	Yes
Theophylline-ephedrine combinations	½ tablet (5 to 10 yr) 1 tablet	Orally	1 hr	No	Yes
Dyphylline	15 mg/kg	Orally	1 hr	Yes	Yes
Theophylline	4 mg/kg	Orally	1 hr	Yes	Yes

*Letter from physician to International Commission must include diagnosis, reason for administration, dose and time of dose.

followed by bronchoconstriction reaching a peak about five minutes after stopping. The most severe bronchoconstriction does not generally occur during the exercise period, but after a brief rest, and it tends to dissipate in about 20 minutes. Baseline pulmonary function generally returns in two hours.[4] Asthmatics may have less EIA as they get older, while in others clinical asthma nearly clears while they remain exquisitively sensitive to exercise.[5,6]

Free running is the most asthmogenic activity, the treadmill is slightly less effective, and cycling and kayaking tend to be considerably less effective.[7] While we have used the treadmill in testing our patients, several clinicians have pointed out the usefulness of the free-running method. Pierson and Bierman[8] ran patients, ranging in age from 5 to 21, on a concrete walk 200 feet in length with a 3% grade to increase the heart rate to 180 beats per minute with good results. They point out that running on a flat surface or downhill may not cause enough stress to induce bronchospasm. Field et al[9] have utilized a submaximal stress test for evaluation of EIA in which patients were exercised to 80% of their predicted maximal heart rate according to a multistage treadmill protocol. Strauss and McFadden[10] have shown, exercising arms and legs separately, that exhausting leg work or exhausting arm work resulted in bronchospasm, while nonexhausting leg work did not, suggesting that the relationship of work load to muscle mass is a determinant of airway obstruction. This may explain the different asthmogenicity of various types of exercise. Fitch[11] has shown that physical training does not lessen the liability for EIA to develop. Forty-five asthmatic children who underwent five months of extensive exercise training had virtually the same fall in $FEV_{1.0}$ after the training period.

The site of obstruction in EIA has been studied by several investigators.[12,13] In most patients with EIA, obstruction is greater in large airways than in small airways. Most recently, McFadden et al[12] demonstrated that exercise in asthmatics is heterogeneous, occurring in both large and small airways, and that cholinergic pathways apparently play some role in the mechanisms.

It has been suggested that the mechanism for EIA is related to acidosis, hypocapnia, or hypercapnia[14,15]; however, recent well-done studies seem to have disproved these theories.[16] Recently, Strauss[17] demonstrated that the inhalation of cold air accentuates the bronchoconstrictor response to exercise in asthma. Despite all the studies, there is considerable disagreement and no clear-cut mechanism has been proven.

Pharmacologic management involves a wide range of drugs that modify the exercise induced response in most patients. (Table 1) Isoproterenol, terbutaline, and metaproterenol are all effective in blocking the response to EIA. Isoproterenol is short-acting and terbutaline must be given orally one hour before exercise to be fully effective. Metaproterenol by inhalation acts immediately and lasts up to three or four hours. Orally, it should be given one hour before exercise. Aminophylline has some effect in blocking EIA, but the blood level must be in the therapeutic range of 10 to 20 ug/ml. Cromolyn has the ability to totally block EIA in some patients. Cox[18] and others have suggested that cromolyn prevents liberation of bronchoconstrictor mediators from storage cells. The drug has no bronchodilator effect and it is usually effective if given immediately before exercise. Godfrey's studies,[19,20] as well as our own, have shown that at least 35-45% of asthmatics will have near total protection from EIA after inhalations of cromolyn. An important factor in the use of these drugs is the timing involved. Patients using these medicines on a scheduled basis may not obtain the relief from EIA found when they are taken at the proper time in relation to exercise.

Corticosteroids, antihistamines, antibiotics, and sedatives have no effect.[21] Atropine has been shown to reduce symptoms of EIA, but the side effects and short pharmacologic activity make this clinically not useful at the present time.[20] Several studies with a longer-acting atropine compound, SCH 1000, look promising.[22]

In summary, an increasing awareness of the possibility of this common problem, especially in asthmatics or patients with allergic histories, can lead to proper diagnosis and treatment. Diagnosis is relatively simple and treatment is almost always beneficial.

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The Epidemiology of Facial Fractures

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Four hundred and three patients with facial fractures were treated by the Department of Oral and Maxillofacial Surgery at the University of Louisville Affiliated Hospitals over a 30-month period. These patients' records were then retrospectively analyzed in order to gain insight into the epidemiological patterns.

BETWEEN January 1973 and July 1975, 403 patients with facial fractures were evaluated and treated by our service at Louisville General Hospital, Children's Hospital, and the Louisville Veteran's Administration Hospital. These patients and their fractures were then categorized into seven groups: isolated mandibular fractures, isolated maxillary fractures, isolated fractures of the zygomatico-maxillary complex (ZMC), combined fractures of the maxilla and mandible, combined fractures of the mandible and the ZMC, combined fractures of the maxilla and the ZMC, and combined fractures of the mandible, maxilla, and the ZMC. Fractures involving only the nasal bones, or the mandibular or maxillary alveolar ridges, were not included in this study.

It is realized that many patients with extensive facial injuries have fracture lines which involve multiple bones, and therefore, the proper categorization of these injuries becomes somewhat arbitrary. It should be noted that the above listed seven categories were derived from Le Fort's original classification, as well as Rowe's and Killey's discussion of facial trauma.[1,2] This system allowed us to list each patient only once. It should also be noted that some patients with severe facial trauma expired prior to their presentation, due to their other injuries. These patients were likewise not included in this analysis.

Findings

Age and Sex

The patients ranged in age from 3 to 92, the mean being 44.4 with the average being 33.6 (Fig. 1). Almost one half (197) of the patients were in the 16-30 age group; three-fourths (301) were in the 16-45 age group. Males predominated by slightly more than 3 to 1 (304/99). These figures are consistent with those noted in other studies and support the concept that facial injuries are far more frequent in the young, mobile and aggressive portion of our population.[3-5]

Etiology

The most common causes of fracture were altercations (44%), motor vehicle accidents (33%), and falls (9%). The remaining 14% resulted from motorcycle accidents, gunshot wounds, sports injuries, pedestrian accidents, miscellaneous, and unknown causes. (Table 1) Altercations resulted in single bone fractures in 94%. Motor vehicle accidents involved single bone fractures in 86%.

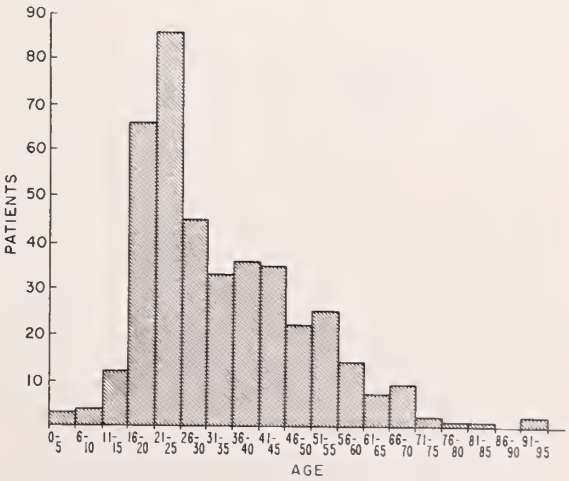

FIG. 1 Age distribution

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Reprint requests to Doctor Alpert.

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Table 1
ETIOLOGY OF FACIAL FRACTURES

	MAND ONLY	MAXILLA ONLY	ZMC ONLY	MAND & MAXILLA	MAND & ZMC	MAX & ZMC	MAND & MAX & ZMC	TOTAL	%
Altercation	136	6	25	1	7	2	1	178	44%
MVA	85	20	10	4	4	6	4	133	33%
Falls	29	0	5	1	1	1	0	37	9%
Motorcycle	6	0	1	1	1	0	0	9	2.2%
GSW	9	0	0	0	1	0	0	10	2.4%
Sports	5	0	1	0	0	0	1	7	1.7%
Pedestrian	3	0	1	1	1	0	0	6	1.4%
Unknown	13	2	1	0	1	0	0	17	4.2%
Misc.*	3	0	3	0	0	0	0	6	1.4%
TOTAL	289	28	47	8	16	9	6	403	

*Hit by horse (2)
Roller coaster accident (1)
Bicycle accident (3)

Other studies have indicated different relative frequencies for the various etiological factors as listed.[6] It is probable that these differences reflect the socio-economic status of the patient population served. It is to be expected that a facility which functions as an inner city receiving hospital will receive a relatively higher number of patients whose injuries are a result of interpersonal action than would a suburban facility whose trauma may be mainly vehicular in nature.

Location of Fractures

The distribution of facial fractures (Table 2) reflects the overwhelming preponderance (71.7%) of isolated mandibular fractures. Isolated ZMC fractures accounted for 11.6% and isolated Le Fort (maxillary) fractures accounted for 6.9%. Only 9.8% had multiple facial fractures. Again, these figures reflect the metropolitan environment. Analysis of Tables 1 and 2 indicate that whereas the interpersonal altercation is by far the most frequent source of injury in this study, it would indeed follow that the most prominent portions of the facial skeleton, excluding the nasal bones, namely the mandible and the ZMC, would be the most frequently injured. In those injuries associated with motor vehicle accidents, of note is the relatively high incidence of isolated maxillary fractures, accounting for 71% (20/28) of all such fractures encountered. This is usually attributed to the rapid deceleration impact injury involving the steering wheel or the dashboard.

As would be expected, 67% (4/6) of all combined mandibular, maxillary, and ZMC fractures were attributable to vehicular accidents and the high forces involved. Nevertheless, the isolated mandibular fracture was still the most commonly encountered injury in these patients. Somewhat surprising is the high incidence of falls as an etiologic factor. Many of these patients were in the geriatric age group and were associated with falls from wheelchairs. Also, a number of these patients were under the influence of alcohol or street drugs at the time of injury. It is not then at all surprising to note the frequent incidence of isolated fractures of the mandible and ZMC in this group.

Concomitant Injuries

Table 3 illustrates that 32.6% (131/402) of patients had concomitant injuries in addition to their facial fractures. The most common concomitant injury was head injury, usually cerebral concussion; 19.6% of the patients in this review had head injury; 13.8% had orthopedic injuries; and 8% sustained chest injuries. Abdominal injuries were seen in 2.9% of patients in this series; 3.2% of patients had severe soft tissue

Table 2
DISTRIBUTION OF FACIAL FRACTURES

Mandible	289
Maxilla	28
ZMC	47
Maxilla and Mandible	8
Mandible and ZMC	16
Maxilla and ZMC	9
Mandible, Maxilla and ZMC	6

lacerations, and 2.4% had ophthalmic injuries, including two patients with superior orbital fissure syndrome and one with orbital apex syndrome. Six of the eye injuries resulted in blindness in the affected eye. Miscellaneous injuries included a fracture of the larynx, an internal carotid artery pseudoaneurysm, a pseudoaneurysm of the facial artery, a spontaneous abortion, and a laceration of the parotid duct. These figures are again consistent with those from other studies, but certain points need to be clarified.[7]

The high overall incidence of concomitant injuries defines the need for careful systemic evaluation of any patient who presents with what appears to be solely facial trauma. Careful neurologic assessment is especially indicated. Somewhat surprising is the relatively low incidence of documented cervical spine injuries, but this must always be ruled out by appropriate radiographic evaluation. The prevalence of severe ophthalmic injuries confirms our feelings that any patient who presents with trauma to the periorbital area should receive a preoperative as well as postoperative evaluation by an ophthalmologist who is experienced in the care of the trauma patient.[8]

It should also be noted that none of the patients in this series required a tracheostomy solely for the management of their facial injuries. This may represent our departmental belief that there are few indications for immediate definitive treatment of facial trauma. Early treatment when done, is aimed at temporary immobilization for airway, hemostasis, and patient comfort. A consistent attempt is made to assure that the patient is systemically stable prior to the definitive operative treatment of the facial injuries. In addition, we tend to treat severe trauma with more external devices as opposed to multiple open reductions which predispose to more edema. This does not mean to imply that the tracheostomy is never indicated in the treatment of facial injuries.

Mortality

Eight patients (1.9%) in this series died as a result of injuries or treatment. (Table 4) Four died secondary to concomitant injuries. Three died following treatment from medical problems related to advanced age and poor systemic condition. One anesthetic death occurred. This figure may seem low, yet this study only includes those patients who lived to treatment.

The treatment of facial fractures is indicated only to restore function and/or to correct resultant cosmetic deformities. When dealing with the older age group, certainly more emphasis must be placed on the former. Two of the three deaths which occurred in the post-treatment period were, in retrospect, due in part to the patient's inability to tolerate additional stresses placed by the initiation of intermaxillary fixation.

Discussion

Certain tendencies and frequencies can be elucidated from this retrospective analysis. These can be enumerated as follows:

1. It is confirmed that maxillofacial trauma is definitely a disease of the young, mobile, and

Table 3
CONCOMITANT INJURIES

	MAND ONLY	MAXILLA ONLY	ZMC ONLY	MAND & MAXILLA	MAND & ZMC	MAXILLA & ZMC	MAND & MAX & ZMC	TOTAL
Chest	24	4	0	3	2	0	0	33
Ortho	37	9	3	2	3	0	2	56
Abdomen	8	2	1	0	0	0	1	12
Neuro	42	10	10	4	4	6	3	79
Ocular	1	5	3	1	3	0	0	13
Non-Osseous								
Soft Tissue	8	0	1	1				10
C-Spine	3							3
Misc.*	4	1						5

*Larynx fracture	1
Pseudoaneurysm of facial artery	1
Pseudoaneurysm of internal carotid artery	1
Spontaneous abortion	1
Parotid duct laceration	1

Table 4
EPIDEMIOLOGY OF MORTALITY OF FACIAL FRACTURES

Pt	Age	Sex	Fracture	Delay	Treatment	Hosp	Systemic Problems	Cause of Death No of Dys Post	Etiology of Fracture	Other Injuries
R.W.	69	M	Mandible R. angle	7 d	CR	4	CHF HBP	2° to intolerance of treatment (Malnutrition, int. bleed. CHF, HCVD)	Fall	Basilar skull fx
C.C.	91	M	Mandible R. body L. body Edentulous	3 d	CE Max & Mand. splints	10	Poor cardiopul reserve	2° to intolerance of treatment (pneumonia & poor intake)	Fall	
D.M.	24	M	Mandible R. body		Died prior to treatment			2° to injuries	Auto-train Accident	Closed Head Inj.
D.D.	21	M	Mandible Parasym.	14 d	CR	60		Anesthetic death	M.V.A.	
J.M.	17	M	Mandible Parasym.		Died prior to treatment			2° to injuries	M.V.A.	Basilar skull fx Ortho fx Chest inj.
R.T.	47	F	Mandible Symp.		Died prior to treatment			2° to injuries	M.V.A.	Cerebral Concuss. Chest inj. Abd. inj.
C.D.	75	M	Mandible R. body L. body	6 d	CR Skeletal pins		CVA	Poor systemic condition	Fall	
S.D.	63	F	Le Fort I		Died 2° to injuries prior to treatment		Cholecystitis	2° to injuries	M.V.A.	Flail Chest Abd and Ortho inj.

aggressive portion of our population. Altercations and motor vehicle accidents together accounted for 77% of all cases reviewed.

2. Most altercations will result in fractures involving a single facial bone, usually the mandible, followed in frequency by injuries to the zygomatico-maxillary complex (ZMC). Isolated injuries to the maxilla as a result of altercation were rare.

3. Vehicular accidents accounted for a relatively higher number of midfacial injuries, and also result in facial injuries of a more complex nature.

4. Falls also result in a high number of facial fractures, again usually to the mandible or ZMC.

5. Concomitant injuries occurred in 37.6% of all cases, the most frequent involvement being the closed head injury. Other areas were involved less frequently, but the severity of these concomitant injuries indicates the need for the careful evaluation of all patients receiving facial fractures.

6. There were no deaths directly attributable to the facial injuries. However, two of the eight deaths in this series were felt to be related to the patients' intolerance of treatment rendered, namely the initiation of intermaxillary fixation in the geriatric age group. This lends credence to our belief that when treating facial fractures in this group, it is imperative to adopt a course of treatment whenever possible, which avoids intermaxillary immobilization.

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Concepts in Oncology: A Course in the Basics of Cancer For the Medical Curriculum

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ONCOLOGY has great potential value as an integrating "discipline" bridging the preclinical and clinical years of medical education and linking medical and graduate education. In spite of this, cancer is covered in the curriculum of most schools of medicine in "horizontal" fashion, fragmented among departments. Students first encounter cancer in static pathologic specimens and, in most curricula, the students' first clinical cancer encounter is likely to be with terminally ill patients. Such approaches fail to exploit the integrative potential of oncology and promote a pessimistic view of cancer.[1,2]

Oncology has begun to emerge as a coherent discipline; an accelerated research effort has increased the rate of generation of new knowledge and unifying concepts. Presenting what we know of the cancer problem now demands a coordinated approach by basic scientists and clinicians. While this calls for restructuring, merging, and coordinating preclinical and clinical teaching of oncology,[3] a survey done under the auspices of the American Association for Cancer Education revealed that most schools of medicine have failed to make appropriate changes.[4]

This report summarizes experience at the University of Louisville Cancer Center in designing and teaching a new course entitled "Concepts in Oncology," for classes of second-year medical students and graduate students as a base for subsequent horizontal[5] and vertical approaches to oncology training.

Course Objectives

The course was designed to provide students with an early opportunity to adopt a rational, scientific, and realistic view of cancer as a phenomenon and as a problem seeking a solution. Specific objectives were: 1) to provide a foundation of knowledge upon which students might construct concepts of cancer as a potentially understandable and controllable disease; 2) to stimulate an appreciation for the importance of cancer prevention; 3) to project to future clinicians a recognition of the power of scientific approaches to cancer problems in their careers; and 4) to arouse enthusiasm, interest, and curiosity in students such that they might consider oncology a worthy future career commitment. The course was also designed to exhibit for both medical and graduate students the need for multidisciplinary approaches to the cancer problem.

Approach

Paraphrasing Wood,[6] good teaching is as dependent on the enthusiasm, interest, and energy of the teachers as on methods; it therefore seemed best to let the experts summarize the central principles of cancer in their specialties. The outline of the course was developed by 16 basic science and clinical faculty and was reshaped until unanimously acceptable.

The faculty is drawn from the departments of surgery, medicine, radiation therapy, biochemistry, obstetrics/gynecology, pathology, community health, pediatrics, and microbiology/immunology. The 16-week course features two, two-hour class sessions each week. The basic format is as follows: 1) The Properties of Cancer Cells (chemical, morphological, behavioral, and metabolic characteristics), two weeks; 2) Carcinogenesis (chemical, viral, radiation), four weeks; 3) Growth and Differentiation of Cancer Cells, one week; 4) Cancer-Host Interaction (genetic, endocrine, nutritional, immunological, other humoral and epidemiological factors), four weeks. The final section of the course summarizes the principles serving as the basis for current detection, diagnosis, and treatment modalities.

Participation by all lecturers in the design of

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the course contributes to its cohesiveness; this is further insured by having two course coordinators attend every session to provide questions to stimulate correlation and interpretation of specific points in terms of overall concepts. The coordinators work to eliminate unproductive duplication and to provide continuity, thereby neutralizing most of the potential problems of having many lecturers.

The basic format for the course sessions consists of lecture-discussions in which emphasis is placed on interpretation of experiments rather than on raw data. Course sessions are interspersed with a number of field trips to tumor conferences. There are also panel discussions involving the course coordinators and lecturers. In lieu of a textbook, key reprints and other materials are made available to the students in advance of each lecture. The reprints help provide examples of the current approaches and thinking characterizing each discipline.

Problems

Some overlap in material covered by individual lecturers occurred, but this was often beneficial. Some of the lecturers felt that lectures were "shallow" because of the breadth of the subject and the time limitation. Perhaps because of the incomplete nature of what is known about cancer, some students complained of lack of "closure" with respect to certain concepts. There were a few complaints from medical students that the material was too basic, and some from graduate students that the material was too clinical. However, there was no significant difficulty in having both medical and graduate students taking the same course, despite some unevenness in student backgrounds.

Evaluation

The identification of the long-term value of courses such as the one described here is difficult, if not impossible, to assess. The ultimate objectives of the course have to do with the future management of disease and with the quality of future research contributions, factors that obviously cannot yet be measured.

The two major exams which were given during the course measured the knowledge and perspective that the students developed. The results indicated that the approach was successful. A detailed questionnaire provided formal feedback to the instructors for improvement of subsequent offerings. The evaluation indicated that more time should be devoted to discussion and to the use of current reprints.

Conclusion

The assumption was confirmed that courses covering the basic biology of cancer are both valuable and necessary in the medical and graduate curriculum. The mixing of medical and graduate students in this course stimulates them to look at the different facets of the cancer problem. We expect to develop an integrated curriculum in cancer using this course as a focus of its scientific component and as a model for organization of a multidisciplinary offering.

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SPECIAL ARTICLES

Findings of the PACT Child Abuse and Neglect Program

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The findings of a treatment program for child abuse and neglect reveal that these problems are highly treatable. Of 467 cases, only four cases of reabuse were reported. Community response to the program was highly positive.

ON June 30, 1975, Norton-Children's Hospitals, Inc., was awarded a $250,000 federal grant under PL 93-247, the National Child Abuse Prevention and Treatment Act of 1974, to develop a demonstration treatment program for the problems of child abuse and neglect. Although this grant was allocated for one year, it was understood from the outset that the funds could be extended for as long as feasible. Therefore, careful planning enabled the staff to continue the program for another nine months, thus increasing its impact. The program proved so highly successful, and the community response was so positive, that upon its termination, community resources were rallied together to form another program, Project FIND (Families Involved in New Directions), located at Norton-Children's Hospital. And, as promised in the February 1976 issue of this *Journal*,[1] the findings of the PACT (Parents and Children Together) program are reported herein.

This program was named PACT because of the positive philosophy this name conveyed to the family of the abused child. A multidisciplinary approach was used with a staff composed of social workers, psychologists, an expressive therapist, a crisis nursery teacher/supervisor, a legal consultant, and several trained lay therapists. The departments of pediatrics and psychiatry of the University of Louisville School of Medicine assigned a pediatrician and psychiatric consultants to the program. In addition, the Metropolitan Social Services Department, which handles all reports of child abuse in Jefferson County, provided a social worker to conduct all investigations. Her salary was paid by PACT, she maintained an office in the hospital, and she functioned as a PACT staff member.

In addition to the development of innovative methods for the early identification and treatment of the problems of child abuse and neglect, a primary goal of the program was to educate and stimulate the community to continue to take action on these problems.

In developing the treatment program, the findings of other child abuse and neglect programs in the country were reviewed; however, in order to allow for maximum innovation and creativity, the patient population was observed and programs were developed to meet their particular problems and needs. Staff feedback and discussion were encouraged, and some of the more articulate patients were invited to sit in on training sessions to discuss their particular experiences and ideas with the staff.

Training of in-hospital staff and community professionals was given high priority; a large number of training sessions were conducted at the various hospitals and agencies, both in Jefferson County and throughout the state. Coordination with other agencies was encouraged to prevent

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overlap and confusion regarding services. For this purpose, case reviews were held periodically with representatives of the various agencies involved in particular cases. These sessions were effective in engendering positive movement with cases which had been involved with a large number of agencies for a long period of time.

As the professionals became more knowledgeable about the signs, characteristics, and histories of families involved in child abuse and neglect, referrals to the program increased rapidly. A booklet, "The Physician's Checkup on Child Abuse and Neglect,"[2] was compiled and provided information for professionals regarding various aspects of the problems of child abuse and neglect. This booklet is being used extensively by other programs throughout the country and is available through the Department of Pediatrics, University of Louisville School of Medicine.

Referrals to the PACT program were received from all hospital departments, community agencies, and from private physicians. During the course of the program, 467 referrals were received. A number of self-referrals were made by persons who were fearful that they might injure a child, or who had other indications of potential for abuse. These persons were immediately involved in the program, preventing the development of more serious problems.

Professionals were alerted to make referrals when certain signs and symptoms were observed. These are as follows:

- multiple injuries, unexplained injuries, or injuries inconsistent with the history given
- dislocations, fractures, burns, marks in the shape of instruments used
- delays in seeking medical attention
- contradictory history
- hospital "shopping"
- failure to thrive
- ingestion of inappropriate food, drink, or drugs
- repeated hospitalizations
- abandonment of the child in the clinic or emergency room
- refusal of parents to obtain diagnostic tests or treatment for the child
- suspicion regarding sexual abuse, trauma to the genitals, venereal disease in the throat or genitals
- unexplained death

Although a number of professionals appeared concerned about the possibility of mistaking an accidental injury for a case of child abuse, the number of inappropriate referrals to the PACT program was negligible. Errors, if any, were in the failure to refer some valid cases of child abuse.

The abusers who presented to the PACT program were found to have certain histories and characteristics which made them fairly easily identifiable. These patterns were, in general, similar to the findings of studies conducted at the University of Colorado by C. Henry Kempe and Ray Helfer,[3] and Brandt Steele.[4] Most abusers referred to the PACT program were:

- abused themselves as children
- immature
- socially isolated
- unrealistic in their expectations of the child
- uninformed regarding good parenting
- made to take responsibility at a very early age
- expected to give to their parents as children
- provided little support from spouse and family
- involved in frequent crises and under stress
- likely to possess very low self-esteem

The most common factor observed was an early history of physical, sexual, or emotional abuse. In many cases, the abusers denied this at first, but further questioning often revealed the occurrence of sexual abuse or severe emotional abuse in their past histories. One woman reported having been raped as a teenager by her uncle. After this happened, she was forced by her aunt, who was her guardian, to get on her knees and apologize to him. This, in addition to physical and verbal abuse by this aunt, was more than she could handle. She ran away at the age of 16 to be married, became a parent shortly thereafter, and when seen by PACT had become involved in negative parenting patterns with her own child. This client was fortunate in that severe abuse of the child was avoided by early referral.

The characteristic of the abusers most often observed was immaturity. This was manifested in impulsiveness, poor judgment, and inability to tolerate stress. A Minnesota Multiphasic Personality Inventory (MMPI) study administered to all abusers in the PACT program essentially confirmed the clinical observations regarding the abusers' characteristics. The results of this study

showed that the most frequently elevated scale on the MMPI was the Immaturity scale.

The cases of neglect seen in the PACT program were viewed as different in several aspects from those of abuse. This problem seems to have a variety of causes. Solutions, therefore, were geared to the individual causes and took a variety of forms. One mother whose children were extremely malnourished was found to be retarded. She did not have a refrigerator, and as a result, the food in the house became spoiled. The answer to this problem? A homemaker and a refrigerator.

Other causes of neglect were severe depression on the part of the mother or caretaker, alcohol or drug abuse, poverty with its associated frustration and "apathy-futility syndrome,"[5] and psychosis. Neglecters in the program appeared less likely to display negative feelings toward the child or to limit the child's social activities. Treatment often involved parent education, medical or psychiatric care for the parent, and concrete help for family economic problems. The lay therapists in the PACT program were especially helpful in providing transportation, support, and help with obtaining food stamps or other services for the family.

The treatment program for the abusers in the PACT program was conceptualized as a process whereby the "empty cup," which most abusers sustained as a result of deprivation in their own childhoods, was filled by the staff. In order to "give" to the child, it appeared that the parents needed first to receive themselves. This was accomplished through providing "mothering" and encouraging dependence by them on staff members for a period of time. Individual counselling sessions with social workers and psychologists accomplished this goal. Group therapy sessions were held in the evenings in order to include all persons living together, such as husband and wife, boyfriend, girlfriend, or other guardians; the idea being that the mate understand the needs of the abuser in order to provide the necessary support. Group therapy provided an atmosphere of understanding and helped to decrease the "charge" on this highly taboo subject when persons heard others in the same situation describe their problems.

A very successful program developed at PACT was the Friendship Club. This involved a group activities program organized to help the abusers develop social skills and participate in recreational activities. The group selected the name, planned activities with the assistance of several lay therapists, and elected officers. Many of these persons who had let their appearance go for some time, began to dress up for the functions and were very enthusiastic about the activities; many reported looking forward to this program all week.

The extreme isolation which they had experienced, the lack of recreation, and the inability to "give" to themselves, which these parents displayed, was rather revealing to the staff. It was common to see mothers at activities such as picnics, sliding down the slides and swinging on the swings, or gleefully enjoying themselves on the Belle of Louisville. Many had never before been to 4th and Broadway, or on a picnic. On occasion, a mother felt such guilt at having enjoyed herself that she would not attend the Friendship Club the following week. In this way, there seemed to be a vicious cycle about the isolation experienced by the abuser, in that he or she felt guilty about abusing the child; therefore would refuse to leave the child. Frustration built up again, and often the abuse reoccurred.

Parent education was a very important part of the program, since many of the abusers had little understanding of the normal development of children and consequently had unrealistic expectations. For instance, a young mother reported she had abused her four-month-old baby because he refused to become toilet trained. A seven-month-old baby was abused for being unable to eat neatly with a spoon. Nurses from the Children And Youth Project, Department of Pediatrics, University of Louisville, conducted sessions on child care, the needs and management of the child, and infant stimulation techniques. These sessions were helpful in assuring the parents that they were capable of providing positive parenting.

It was found that a number of abusers had taken an unusual amount of responsibility as children and had dropped out of school at an early age in order to take care of their younger brothers and sisters. Because of this, they lacked skills, were economically insecure, and displayed very low self-esteem. These persons were encouraged to enroll in the GED (General Equivalency Diploma) Program, where they worked toward obtaining their high school diplomas. Staff members arranged for them to become enrolled in the

Table 1

REFERRAL SOURCES

Source	% Referrals
Hospital	
Emergency Room	24
Private Physicians	10
Other hospital departments	12
Specialists (M.D.)	6
Residents	4
Community	
Self	14
Protective Services Agencies	11
Relatives	3
Other agencies	7
Other hospitals	3
River Region Crisis Center	3
Private Physicians	2
Courts	1

program and provided support by accompanying them to the initial sessions. As a result, a number of parents received their diplomas; several enrolled in college, one in the nursing program.

The children's therapy program included individual evaluations of the child, group expressive therapy sessions, and a therapeutic playschool program at the crisis nursery. This nursery was organized through an affiliation with the local Red Cross and was located within walking distance of the medical center. The crisis nursery provided an opportunity for the parent under severe stress to leave the child there, without questions asked, and to receive the needed respite from the child. Children brought to the nursery were assessed for their physical and emotional states; were given a snack, which was often necessary because they had not eaten all day; and were immediately involved in the therapeutic nursery program. The WHAS Crusade for Children provided equipment and emergency meals, and the Red Cross provided an assistant teacher/therapist. The abused and neglected children in the PACT program were also evaluated at the University of Louisville's Child Guidance Clinic and Child Evaluation Center.

Involving families in the program was not usually difficult once a relationship was established. Hostility was often encountered on the first interview; however, staff members were trained to provide a combination of firmness regarding ensuring the child's safety, warm support, and understanding to the parent. Focusing on the parents' needs and problems generally proved successful in eliciting their cooperation.

Kentucky law, KRS 199.011, which provides authorization for the hospital to hold the child for 72 hours without written consent of the parents, was invoked when necessary. This generally provided enough time for the staff to evaluate the child and to begin working with the parents. The court was used, when necessary, to motivate parents to enter the PACT treatment program; the progress of these parents was reported back to the court at regular intervals.

A very high level of safety was maintained in the PACT program. Of the 467 cases seen during its period of operation, only four cases of reabuse were noted. This was accomplished first by a safety-monitoring system whereby each case was reviewed on a regular basis for particular safety factors. High case loads, which are known to affect the safety of children, were handled by a priority system, and charts were marked so that high risk cases were easily identifiable at all times. Also, because the protective services worker was maintained as a member of the staff, it was possible to coordinate the investigation with the treatment plan and to keep the staff continually informed of the safety status of the child. In addition, the staff was on call and available on a 24-hour basis. Parents were encouraged to call their therapists when the stress began to build up. In general, they felt free to seek help when they felt insecure about their impulses.

Statistical Data

Referrals to the PACT program began as soon as the doors opened and continued on a very high level throughout the program period. Of the 467 referrals, 84% were from Louisville and Jefferson County. Thirteen percent were residents of other counties throughout the state, and 3% were out-of-state clients, mainly from Southern Indiana. The largest referral source was the hospital emergency room. The second-largest source was self-referrals, mostly of a preventive nature. As the program received more publicity, and persons under stress became aware of its existence, the number of these prevention cases increased. Table 1 describes referral sources from Norton-Children's Hospitals and from the community.

Children presented to the program with all types of injuries. The most common injuries were bruises, welts, scars, and cuts. Of all children

seen, 56% had sustained multiple injuries, including combinations of bruises, burns, and fractures. During the program period, there were six deaths upon admission, four due to abuse and two due to severe malnutrition and neglect. Of all cases, 33% were victims of neglect. This rather high figure is in keeping with national studies[6] which report three cases of neglect to each case of abuse. Table 2 lists the types of injuries seen in the PACT program.

The largest number of families seen were from the lower economic group, probably because of the large number of referrals received through the emergency room and from the protective services agencies. Approximately 76% of all families were of the lower economic class, and 25% of all referrals were mothers on public assistance. As the program progressed, there was a gradual trend toward increased referrals by private physicians. This was attributed mostly to their becoming more informed, both about the program and the signs of child abuse. As these referrals increased, more middle-class and upper-middle-class families were seen in the program. This finding corresponds with reports of child abuse programs throughout the country, indicating that the problem essentially cuts across all economic lines.

Regarding ages of the abused children, the largest number were from the 1-3 year group, with the next largest group being 3-6 years old. Table 3 shows percentages of children from each age group.

Fewer cases of teenage abuse were noted than expected, probably because abused teenagers often manifest other symptomatology whereby they become runaways or delinquent, and are seen by other programs. Two teenagers referred to the program had made suicide attempts. In one case, a teenager was admitted to the hospital for a diabetic reaction; when she subsequently refused discharge, it was discovered that she had been sexually abused by her father and was afraid to return home.

Table 2

TYPE OF INJURY

Injury	% Children
Bruises, welts, scars, cuts	37
Burns	10
Fractures, skull	8
Emotional abuse	6
Sexual abuse	6
Fractures, bone	6
Ingestion of inappropriate substance	5
Brain damage	5
Subdural hematoma	5
Dislocations	4
Head trauma	2
Internal injuries	2
Attempted strangulation	2
Unspecified	2
Multiple injuries (combinations of above)	56
Neglect, all types	33

Table 3

AGE OF THE ABUSED CHILD

Age of Child	% Children
0-1 month	2
1-3 months	7
3-6 months	8
6-12 months	10
1-3 years	29
3-6 years	26
6-12 years	13
12-18 years	5

Of all children seen, there were slightly more males than females, with 53% male and 47% female children. More white children were abused than blacks, with 57.7% white, 41.4% black and 0.9% biracial children. The oldest child or only child was most likely to be abused. In 43.8% of all cases seen in the program, the oldest child was seen most often, in 27.4% the second child, and thereafter percentages decreased according to birth order. In one case, the 11th child was abused, with no known abuse to the other children. Reasons for this unusual situation were not known.

Quite a few more mothers than fathers were found to have been the abusers. This is most likely attributable to the fact that more mothers were caretakers of the children. Fathers who abused were often either widowed, divorced, or stayed at home to take care of the children while the mother worked. A considerably higher number of mothers' boyfriends than fathers' girlfriends were identified as the abusers, no doubt because girlfriends in the program were much less frequently living in the home with the children, nor were they the primary caretakers of the children. This is likely because custody of children living with separated parents was usually granted the mother. Table 4 shows the relationship of the abuser to the child.

Much community support and publicity was generated by the PACT program during the

Table 4

ABUSER Abuser	% Total
Mother	59
Father	22
Boyfriend	7
Girlfriend	0.4
Babysitter	2
Relative	0.5
Foster parent	0.9
Institutional abuse	0.4
Teacher	0.5
Step parent	3
Unknown	4
Both parents (figures included above)	16

course of its operation. As the program neared its termination date, an advisory committee, composed of professionals and lay persons, examined a number of possibilities for continuing child abuse services in the community. As a result, a new program was developed, involving a coordinated community effort. This program, called FIND (Families Involved in New Directions), is presently based in the hospital and is continuing to provide treatment services to a large number of abused children and their families.

Of the many lessons learned during the course of the PACT program, probably the most dramatic was that persons who abuse their children prove to be highly treatable. When involved intensively in a full range of treatment programs, these persons were usually rehabilitated in 10-12 months. Follow-up of these cases was recommended for at least a period of one year. Sadly, most abusers reported having sought help for a long time prior to their involvement with the PACT program. Many, who were at first very hostile, volunteered to be interviewed on television and by the newspaper in an effort to reach others who might need help.

In light of this, it is very encouraging that child abuse and neglect treatment programs are springing up in communities throughout the country, and that increased emphasis is presently being placed by the federal government on research and demonstration programs in these areas. Additionally, a number of preventative efforts are now in progress throughout the country. Perhaps the time has finally come when we have begun to place priority on one of our most important resources—our children.

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EDITORIAL

Kentucky's Successful Primary Care Program

A series of articles relating to social, political, and economic aspects of medicine have recently appeared in the New England Journal of Medicine. An especially interesting article on primary health care appeared in the May 11, 1978, issue of this Journal. In essence, the authors have abstracted from a larger report on primary health care and delivery submitted by a committee of the National Academy of Sciences. The recommendations of this committee are rather far-reaching, involving such matters as medical school curriculum changes, priority allocation of postgraduate training positions for primary care residents, reimbursement equalization, and the expanding role of physician assistants and nurse practitioners.

The two medical schools of Kentucky have in a sense preempted the recommendations of this committee. For some years now, a growing emphasis on primary health care needs has resulted in substantial and rewarding curriculum changes at these schools. These include, among other things: 1) expanded courses in behavioral and social sciences relevant to patient care, 2) active and growing departments of family practice, and 3) rotation of students in a variety of primary care settings, including those in smaller urban and rural communities.

Initial exposure to primary care at the University of Louisville begins to a significant degree during the sophomore year in two courses. One of these is a "core course" in behavioral science taught by faculty members of the Department of Psychiatry. Clinical experience in a primary care setting is initiated during the fourth quarter of the sophomore year, during which time students spend four afternoons in the offices of family practitioners. This early emphasis on postprimary care has not detracted from the traditional first two years' basic science core curriculum, though some decrease in elective time during these years has resulted.

Greatest emphasis on primary care occurs during the fourth year, permitting students a wide variety of educational experiences. One of these—the Rural Health Tutorial Program—has been enormously successful. The purpose of the program is to provide a positive medical education in a nonurban setting, permitting the student clinical, community, and practice management experience. Needless to say, the success of this program has required continual cooperative efforts of the two medical schools and sustained dedicated participation by physicians of every area of this state.

Other primary care experiences are available in urban areas as well as on-campus and off-campus settings.

It would appear to this observer that the two medical schools of this state have responded in a most positive manner to the need for more primary care physicians. Major problems of physician distribution, reimbursement differential for identical services, and retention of physicians in primary care roles remain. These problems cannot be solved by physicians alone; they require and demand appropriate attention from communities and from health care consumers.

GRS

"Each member of the AMA must be motivated to take an active role in furthering the ideals and goals for which we stand. Our collective efforts and mutual advance depend on individual commitment—commitment to unity and complete service. Only in that way can we safeguard the future of American medicine."

Hoyt D. Gardner, M.D.
Nominee for President-Elect of the American Medical Association

WE have known Hoyt Gardner for a long time and recognize that his name has become virtually synonymous with the activities of organized medicine in Kentucky. He is currently a nominee for President-Elect of the American Medical Association. In this turbulent period, we pause to reassess this man who would be our spokesman.

Hoyt Gardner first came to our attention through his activities and student leadership at the University of Louisville School of Medicine. His recognition for academic achievement with Alpha Omega Alpha and leadership with Omicron Delta Kappa was noteworthy.

He left Kentucky for a residency at Henry Ford Hospital and a second period of military service in the Air Force during the Korean conflict. On returning to Louisville, and beginning solo practice in general surgery, he became a Diplomate of the American College of Surgeons and joined our Associations.

Five years before his graduation from medical school he married Rose, an intelligent, poised, and concerned person. Today she is active in local, state, and national medical affairs, serves as First Vice President of AMA Auxiliary, has worked on a Presidential Commission, and has won the respect and admiration of those of us who know her.

Hoyt's obvious talents to get things done inevitably resulted in his selection for positions of increasing responsibility locally and statewide. His keen perception was noted almost 20 years ago when he warned us of impending legislation that "would establish a socialistic principle and pass over responsibility for a person's health to the government."

For over 11 years he counselled us and the state Association as Chairman for National Affairs of the Kentucky Medical Association Committee on Legislative Activities. His understanding of the political process has been unswervingly accurate. He advised us of battles to be waged in the political arena and warned us of the consequences of failing to support our Medical Political Action Committees.

As an articulate spokesman with political acumen and a demonstrated talent to lead, he was appointed to the Board of the American Medical Political Action Committee, later became its Treasurer, and served as its Chairman.

Medicine was not alone in recognizing his ability, integrity and dedication. Those of us who trained or now work at the Louisville General Hospital have often struggled to deliver care in facilities conceived at the turn of the century. Despite two decades of attempts to build a new city-county teaching facility—including a successful bond issue—the project remained dormant until a concerned citizen and assistant clinical professor of surgery, Hoyt Gardner, became Chairman of the Louisville-Jefferson County Board of Health. We attended meetings of the Board, watched him thread the labyrinth of Washington, and came inescapably to the conclusion that the new multimillion dollar hospital complex being built today on Chestnut Street is in no small way a tribute to the effective leadership and unselfishness of Hoyt Gardner.

His presidency of the Jefferson County Medical Society was characterized by planning, foresight and achievement. Programs then initiated remain in effect and long range planning for the Society remains a keystone of its vitality and effectiveness.

The physicians of Kentucky then selected him to serve as President of the Kentucky Medical Association. We recall his travel through the state and grass roots involvement of his colleagues. He conscientiously carried out the mandates of the House of Delegates and Board of Trustees.

The Governor of Kentucky appointed Hoyt Gardner to serve on the Board of Trustees of the University of Louisville during a difficult transition period for the school. He became Chairman of this Board.

Hoyt has been elected twice to the Board of Trustees of the American Medical Association.

We have heard him speak unequivocally of the issues affecting medicine and its individual practitioners. He has abhorred unwarranted government intrusion and invasion of privacy. He has decried contradictory social schemes which would substitute cost accounting for quality medical care. He has opposed charlatanry.

He has met the test of leadership in that wherever he has served, he has left "behind him a situation which common sense, without the grace of genius, can deal with successfully . . . (and) . . . other men the conviction and will to carry on."

This *Journal* endorses Hoyt Gardner for President-Elect of the American Medical Association without reservation and with the knowledge that we could not be better served.

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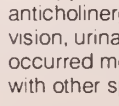

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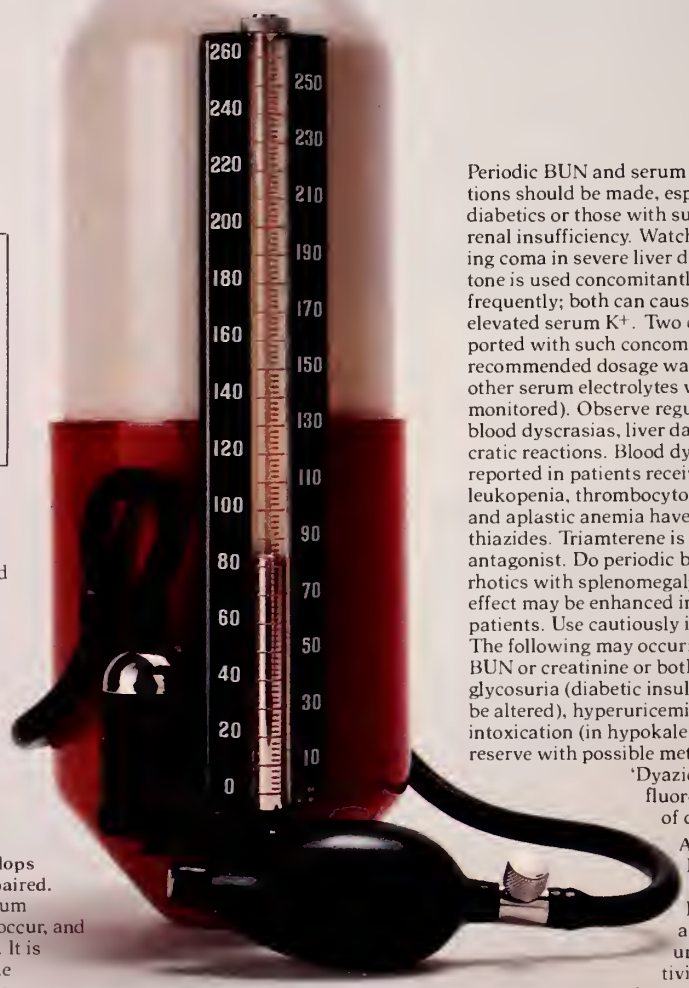

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Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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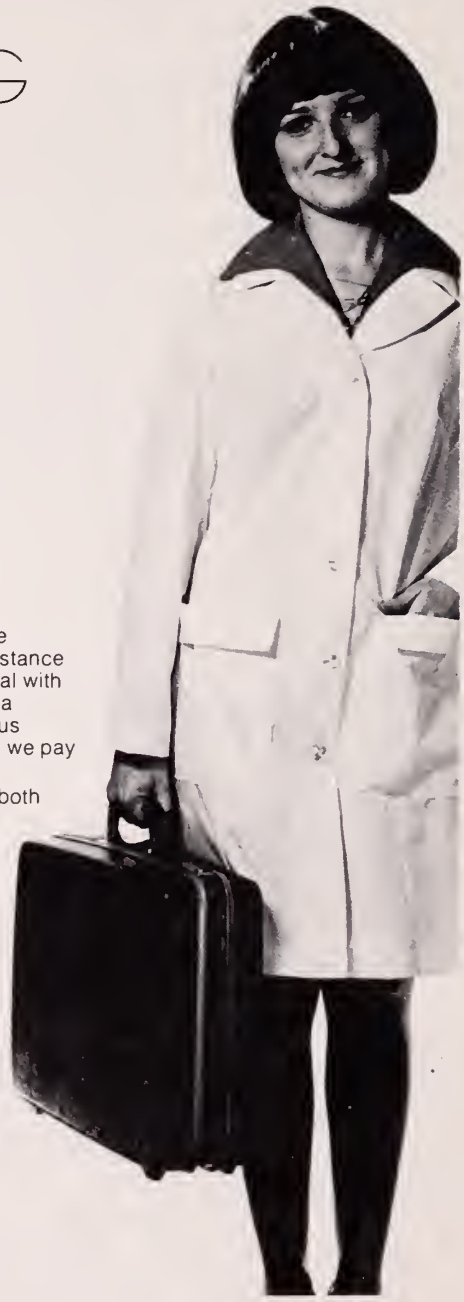

Daneman Laboratories' space-age electronics technology and two long-distance telephone calls will provide your hospital with same-day EEG and ECHO readings by a qualified neurologist. Even instantaneous reports can be provided if needed. And we pay for the phone calls!

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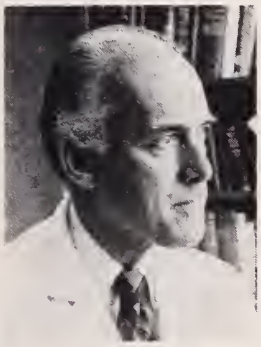
ASSOCIATIONAL NEWS

Guest Speakers Will Discuss Wide Range of Scientific Topics At 1978 KMA Annual Meeting—September 24-28

Medical authorities from across the nation will be featured on the scientific program planned for the KMA Annual Meeting, to be held September 24-28 at the Hyatt Regency/Lexington Convention Center in Lexington.

Guest speakers, representing 19 medical specialties, will discuss wide-ranging topics to include pulmonary disease, craniofacial surgery, occupational factors in cancer, and management of obesity.



Doctor Maloney

Doctor Georgiade

James V. Maloney, M.D. will speak Tuesday morning, September 26, on the "Pros and Cons of IPPB." Doctor Maloney is Chairman of the Department of Surgery at the University of California Medical Center, Los Angeles, California. He is a Fellow of the American College of Surgeons and is a member of the American Association for Thoracic Surgery. His numerous honor awards include the John H. Gibbon, Jr. Lectureship, American College of Surgeons, and Visiting Professor of Surgery, Northwestern University.

Wednesday morning, September 27, Nicholas G. Georgiade, M.D., Professor and Chairman, Division of Plastic, Maxillofacial and Oral Surgery at Duke University School of Medicine, will speak on "Craniofacial Birth Defects and Their Surgical Correction." A Fellow of the American College of Surgeons, Doctor Georgiade is a past President of the American Society of Maxillofacial Surgeons.

Also scheduled to speak Wednesday morning is Bruce W. Karrh, M.D. Corporate Medical Director for E.I. duPont de Nemours and Company, Wilmington, Delaware. Long active in industrial medicine, Doctor Karrh's subject is "Cancer Caused By Occupational Factors: A Perspective." A graduate of the Medical College of Alabama, Doctor Karrh has been active in environmental research since 1970.

George L. Blackburn, M.D., Ph.D., also will speak Wednesday morning on "The Role of the Physician in

Doctor Karrh

Doctor Blackburn

Obesity—Use of Rapid Weight Loss Supplemental Fasting Techniques." Doctor Blackburn is Associate Professor of Surgery at Harvard Medical School and is a member of the Cancer Research Institute, New England Deaconess Hospital, Boston.

Activities other than the four general scientific sessions and the 19 specialty group meetings include: KMA House of Delegates meetings on September 25 and 27, and the President's Luncheon on September 27.

More about the 1978 KMA Annual Meeting will be published in upcoming issues of *The Journal* and "Communicator."

Professional Liability Insurance From KMA Insurance Agency Now Available

Kentucky physicians may now apply for medical professional liability coverage for immediate effective dates. This announcement by Douglas J. Freeman, General Manager of the KMA Insurance Agency, Inc., follows the recent licensing and rate approval of the Physicians Insurance Company of Ohio (PICO) by the Kentucky Department of Insurance. (Physicians wishing to apply should complete and return the application sent them in late May by the Agency.)

Limits of coverages available include: primary policies with limits of either $100,000 per claim/$300,000 aggregate per year or $200,000 per claim/$600,000 aggregate per year, plus an excess policy of $1,000,000 per claim/$1,000,000 aggregate per year, sold only over a $200,000/$600,000 primary policy. The Agency will provide excess coverage to physicians currently carrying $200,000/$600,000 primary coverage with another approved insurer.

Unique features of the PICO's product include:

- Corporation and partnership coverage provided at no charge, if all members are PICO insureds
- Low-interest financing of premiums (down payment of 25% required; balance billed in 10 equal monthly installments) through PICO's Medical Premium Finance Company, and
- Physicians written consent required prior to the out-of-court settlement of any claim.

The availability of these PICO Medical Professional Liability policies is a result of the efforts of the KMA to establish its own insurance company. The KMA Company will be capitalized through participation by policyholders and non-policyholders in a manner now being finalized. Because of the immediate need of many Kentucky physicians, the PICO policies are being sold in advance of the start of the capitalization effort. The KMA Insurance Agency will not initiate any policy without policyholder participation after the capitalization mechanism has begun to function. Physicians who purchase insurance in the interim should understand that they will be called upon to assist in capitalization as soon as details have been finalized.

Digest of Proceedings Board of Trustees April 6, 1978

The KMA Board of Trustees met on April 6, 1978 at the Headquarters Office in Louisville.

The Headquarters Office Report included remarks by Robert G. Cox, Executive Vice President of KMA, who outlined KMA's current activities, plans and staff changes in assignments. The Board reviewed and approved the 1978-79 budget.

The Medical Licensure Board reported on its present efforts to draft regulations to certify paramedics. Paramedic certification was made the responsibility of the department as the result of action taken by the 1978 Kentucky General Assembly.

Carl Cooper, Jr., M.D., President-Elect and Chairman of the Committee on State Legislative Activities, reviewed activities of the Legislative Committee during the 1978 Kentucky General Assembly. Doctor Cooper reported that the KMA legislative program was successful.

Carl L. Wedekind, Jr., reviewed the status of the Board's decision to intervene in the lawsuit regarding the Patients' Compensation Fund. He emphasized KMA's position that the money in the Fund should be returned as soon as possible, with accumulated interest, to those who contributed to the Fund. Mr. Wedekind noted KMA's objection to any money being drawn from the Fund to pay court costs or attorneys' fees.

Other Board actions:

- Sent nominations to the Governor of physicians to serve on governmental advisory councils.
- Recognized William P. McElwain, M.D. for his service as Commissioner for Health Services.
- Presented AMA-ERF checks from the Auxiliary to representatives of the two medical schools in Kentucky.

Auxiliary Convention Features Elections, AAMA President

The Annual Convention of the Auxiliary to KMA was held April 25-26 at Barren River State Park. Mrs. Charles H. Nicholson, Lexington, was installed as AKMA President, succeeding Mrs. Tom E. Hall, Bowling Green, who presided over the meeting.

Auxiliary members chose Mrs. Gordon Betts, Somerset, to serve as President-Elect. Other officers elected were: Mrs. Bennett L. Crowder II, Hopkinsville, 1st Vice President; Mrs. Paul E. Lett, Ashland, 2nd Vice President; Mrs. Warren M. Cox, Louisville, 3rd Vice President; Mrs. Maurice J. Mueller, Ft. Mitchell, 4th Vice President; Mrs. Allen L. Sklar, Lexington, Treasurer; and Mrs. Wm. W. Spalding, Louisville, Recording Secretary.

Highlights of the two-day session included presentations by the KMA President, John P. Stewart, M.D. and the President of the AMA Auxiliary, Mrs. Chester L. Young. The Auxiliary was congratulated on its recent activities in the Kentucky General Assembly, having hosted a legislative luncheon on February 28. The Nelson County Auxiliary, which was recently formed, was recognized as the 30th organized auxiliary in the state.

The Fall Board meeting will be held in September in conjunction with the KMA Annual Meeting at the Hyatt Regency Lexington. The AKMA Annual Convention is scheduled for next April in Lexington.

U of L Alumni Activities

The University of Louisville Health Sciences Center Relations Office will coordinate an alumni information booth during the 1978 KMA Annual Meeting to be held September 25-28 in Lexington.

In addition, a medical alumni reception will be held on September 26. Various reunions have been scheduled and coordination with the Relations Office would be appreciated. Further information concerning reunions of classes ending in "3" or "8" can be obtained by contacting Billie Clary at (502) 588-5783.

Mrs. Alma Hall, Auxiliary President, presents AMA-ERF checks to Arthur H. Keeney, M.D. (r) Dean, University of Louisville School of Medicine ($12,393.75) and James B. Holloway, Jr., M.D. (l) representing the University of Kentucky College of Medicine ($6,059.74).

Dept. of Human Resources Names New Officers

The appointment of Stanley Hammons, M.D., as Chief Medical Officer, was recently announced by Secretary of Human Resources, Peter Conn. Robert Slaton was named Commissioner of the Bureau for Health Services.

Doctor Hammons' post, created by the 1978 General Assembly, will become effective September 1. As Chief Medical Officer, he will be responsible for evaluating both medical personnel and services provided by the Department. Doctor Hammons is a graduate of the University of Louisville School of Medicine and studied community medicine at the University of Kentucky College of Medicine.

Mr. Slaton, a native of Hopkins County, has served as Mr. Conn's senior administrative assistant since last year.

Ky. Academy of Eye Physicians And Surgeons Meet

Approximately 100 members attended the annual meeting of the Kentucky Academy of Eye Physicians and Surgeons, held April 21-22 in Lexington.

Arthur H. Keeney, M.D., Dean of the University of Louisville School of Medicine, gave the annual banquet address and was among the program leaders.

A special guest speaker was Samuel Dace McPherson, M.D., President of the American Ophthamological Society.

Trustees' Report

TENTH TRUSTEE DISTRICT

James B. Holloway, Jr., M.D.

The most exciting thing in the Tenth Trustee District at the moment is the fact that the Central Kentucky Blood Bank is changing its name to The Eastern Kentucky Blood Bank. We are putting on a drive to fund a $600,000 Fayette County Health Department Building, which we are purchasing from the health department, as it prepares to move to a new building on the north side of town.

This building will be occupied by the Fayette County Medical Society and the blood bank. The blood bank has long needed an expanded role in the community and, indeed, in the entire state. This will allow us to carry on research and adequately serve the eastern half of the state and expand our facilities to meet the expanding needs of this area.

All who are interested in contributing to this, please get in touch with Mr. Tom Watts, at the Blood Bank, 731 S. Lime, Lexington, Kentucky. We are desperately in need of funds. This is a charitable organization and donations are tax deductible.

FOURTEENTH TRUSTEE DISTRICT

Harvey A. Page, M.D., Pikeville

Considering the many drawbacks and obstacles thrown in our path, it is amazing what the people of Eastern Kentucky and District 14 have done, especially this past year.

First, we had the flood, which everyone knows about, and we are proud to say that the hospital has made a complete recovery and is back in full operation, although we are in need of a pathologist at this time.

The nursing home had to be completely renovated, which took quite some time, but this was finally accomplished and it was opened for the reception of patients in December.

The next obstacle was a wildcat strike by the UMWA, which drastically cut the medical benefits of the miners, their families, and the pensioners. Then contract time came about six months later, and it was time to negotiate a new one for the coming three years. This strike for a new contract became the longest one in the history of the UMWA.

Finally, the contract was settled, and now that it is over, peace once again prevails in the mountains and hollows of this District.

The massive cut-through project continues at a snail-like pace, under the capable direction of the Mayor of the city of Pikeville, William C. Hambley, M.D.

Ballard W. Cassady, M.D., a former trustee of the 14th District, has been selected as chairman of the new KMA Insurance Agency under the guidance of Physicians Insurance Company of Ohio.

On May 16th, the 14th District will hold its annual meeting. There will be a scientific program and the featured speaker will be Mr. David Rader of Physicians Insurance Company of Ohio.

Did you know . . .

The Baptist Hospitals, Inc. Board of Directors announces that, effective April 17, 1978, the name of Kentucky Baptist Hospital, Louisville, has been officially changed to **HIGHLANDS BAPTIST HOSPITAL.** The address, telephone numbers, and staff will remain the same; only the name is changed.

****

The nation's medical schools this year will receive $1,150,000 in AMA-ERF unrestricted grants. The grants are made possible by the contributions of individual physicians and medical societies, the fund-raising efforts of medical society auxiliaries, and donations from others wishing to support medical education. AMA-ERF grants to medical schools have averaged more than $1 million annually for the past 28 years.

Headquarters Activity

MAY

2	Thirteenth Trustee District, Ashland
4	Committee on Community and Rural Health, Louisville
4	Ad Hoc Committee on Hospital-Based Physicians, Louisville
8-10	Kentucky Hospital Association Annual Meeting, Louisville
9	Tenth Trustee District, Lexington
9-13	Kentucky Chapter, American Academy of Family Physicians Annual Meeting, Louisville
10	Certificate of Need Board, Louisville
15	*Journal* Editors, Louisville
16	Fourteenth Trustee District, Pikeville
17	Eleventh Trustee District, Richmond
18	Rural Kentucky Medical Scholarship Fund Board of Trustees, Louisville
19-20	Kentucky Surgical Society Meeting, CME Committee, Louisville
23	Second Trustee District, Owensboro
24	Cancer Committee, Louisville
25	Seventh Trustee District, Frankfort
31	Committee on School Health, Physical Education & Medical Aspects of Sports, Shelbyville

JUNE

2-3	Kentucky Ob-Gyn Society Annual Meeting, Louisville
3	Maternal Mortality Study Committee, Louisville
4-6	Washington Dinner, Washington, D.C.
7	McDowell House Board of Managers, Danville
7-9	KMA Emergency Medical Services Conference, Louisville
8	Auxiliary Health Careers Day, Louisville First Trustee District, Paducah
12	*Journal* Editors, Louisville
13-15	FLEX Exams, Louisville
14	Judicial Council, Louisville
15-16	AAMSE 1978 National Educational Conference, St. Louis
16-22	AMA Annual Meeting, St. Louis

Members in the news

NEW MEMBERS

BELL

Charles Khuri, M.D., Middlesboro

JEFFERSON

Sheldon Chase, M.D., Louisville
Aftab A. Chaudry, M.D., Louisville
Julia Chen, M.D., Louisville
Robert David Cox, M.D., Louisville
Edward C. Cummings, M.D., Louisville
David R. Cunningham, Ph.D., Louisville
Renee Gamboa, M.D., Louisville
William S. Gegg, M.D., Louisville
David H. Goldstein, M.D., Louisville
S. Lyle Graham, III, M.D., Louisville
Robert Greenberg, M.D., Louisville
Ferdinand E. Greifenstein, M.D., Louisville
Bijan Hafezi, M.D., Louisville
James M. Hinkebein, M.D., Louisville
David M. Humphrey, M.D., Louisville
William J. Jackson, M.D., Louisville
Rama M. Jager, M.D., Louisville
Margaret Johnson, M.D., Louisville
Sandra E. Johnson, M.D., Louisville
Young Chul Kim, M.D., Louisville
Larry Edward Martin, M.D., Louisville
Richard S. Miles, M.D., Louisville
David P. Moore, M.D., Louisville
Joan C. Paust, M.D., Louisville
Alfonso Puerto, M.D., Louisville
Herbert M. Reiman, M.D., Louisville
Evelyn S. Salisbury, M.D., Louisville
Tsu-min Tsai, M.D., Louisville
Peter H. Wayne, III, M.D., Louisville
George E. Webb, M.D., Louisville
Thomas W. Wolff, M.D., Louisville

In Memoriam

FRED M. WILLIAMS, M.D.

Louisville

1915-1978

Fred M. Williams, M.D., died on May 3 at the age of 62. An anesthesiologist, Doctor Williams was a 1939 graduate of the University of Illinois College of Medicine. He was a member of the Transylvania Society, the American and Louisville anesthesiology societies, the Jefferson County Medical Society, and the Kentucky and American medical associations.

LOOKING AHEAD

June 17-22 AMA Annual Meeting, St. Louis

September 24-28 KMA Annual Meeting, Hyatt Regency, Lexington

October 14 Regional Meeting, American College of Physicians, Lexington

The Eighth Annual

PERIPHERAL VASCULAR DISEASE Symposium

under the chairmanship of

William E. Evans, M.D.

September 14-16, 1978

at

Saint Anthony Hospital

featuring presentations by:

John Bergan, M.D.
Professor of Surgery and Chief of Vascular Surgery at Northwestern University

Ronald Stoney, M.D.
Professor of Surgery, University of California

Malcolm Perry, M.D.
Professor of Surgery and Chief of Vascular Surgery at Cornell University College of Medicine

H. Brownell Wheeler, M.D.
Professor and Chairman of the Department of Surgery University of Massachusetts

also

Vascular Lab Workshops

$125.00 registration

16 - C.M.E.'s granted

Limited to the first 250 registrants

Mail checks to Mrs. Dale Nelson, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus, Ohio 43203

Enclosed is my check for $_____ to cover _____ reservations.

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Address _____

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Please check ☐ Send hotel reservation card ☐ Will need transportation between hospital and hotel

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	Doctors Office Bldg.	Liberty at Floyd	583-7909
	Medical Arts Bldg.	1169 Eastern Parkway	452-2332
	Professional Bldg. East	3101 Breckinridge Lane	459-0133
	Medix Bldg.—Adj. S.S. Mary & Elizabeth Hosp.		367-2277
	Broadway Bldg.	224 E. Broadway	583-7137
ST. MATTHEWS	313 Wallace Avenue		895-9155
	108 McArthur Drive		895-3855
	901 Dupont Road at Breckinridge Lane		897-3264
NEW ALBANY	Professional Arts Bldg.	1919 State Street	945-2802
BOWLING GREEN	Greentree Shopping Ctr.	900 Fairview Ave.	843-6556
OWENSBORO	Doctors Bldg.	1001 Center Street	684-1508
	Lincoln Professional Ctr.	2816 Veach Road	685-4725
GLASGOW	Happy Valley Center	409 Happy Valley Rd.	651-5113

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Owensboro	Lincoln Professional Ctr. • 2816 Veach Rd.

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ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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Volume 76
Number 7

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MDS

HOYT D. GARDNER, M.D.
AMA PRESIDENT-ELECT
1978-1979

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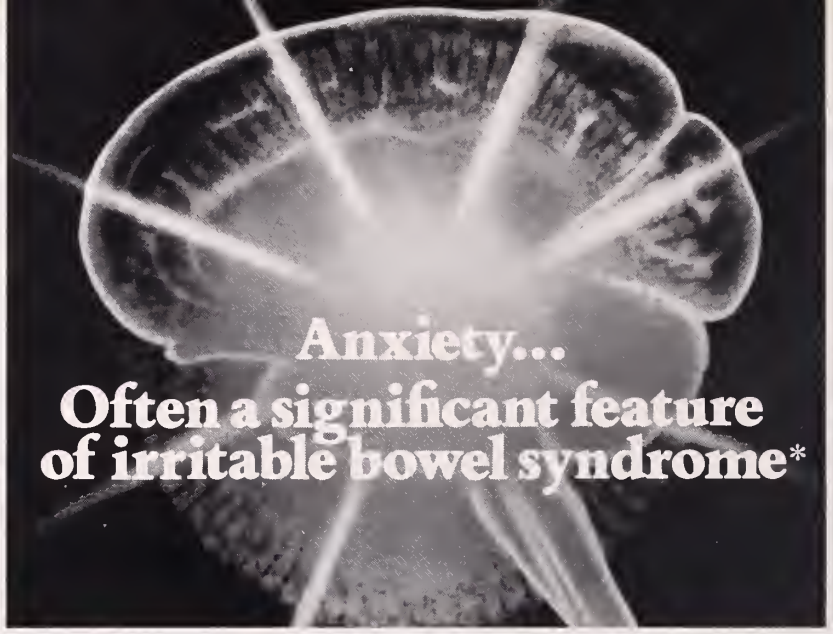
The Journal Of The Kentucky Medical Association



Anxiety...
Often a significant feature of irritable bowel syndrome*

The action of Librium®
(chlordiazepoxide HCl)

A significant advantage of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among GI medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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24-28 Topics in Maternal/Fetal Medicine, University of Louisville Department of Ob/Gyn, Louisville

AUGUST

14-18 3rd Annual Family Medicine Review**, Galt House, Louisville

23 "Common Athletic Injuries**," Louisville CME Consortium, Suburban Hospital, Louisville

SEPTEMBER

21-23 "Gynecologic Surgery," University of Louisville Department of Ob/Gyn, Louisville

24-28 KMA Annual Meeting, Hyatt Regency/Lexington Convention Center, Lexington

OCTOBER

4-6 Clinical Cancer, Kentucky Baptist Hospitals, Louisville

14 Kentucky Chapter, American College of Physicians Regional Meeting, Louisville

18 John Walker Moore Lecture, Health Sciences Center, Louisville

25-26 Hypertension—1978, Galt House, Louisville

IN SURROUNDING STATES

SEPTEMBER

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MESSAGE FROM THE PRESIDENT

Apathy, Disinterest, Hopelessness, Self Pity

PHYSICIANS are individualists, staunch supporters of freedom and individual responsibility. As a group—intelligent, energetic, decision-makers with courage to calculate and take risks, compassionate, generous. Doers and achievers who believe in quality performance, and survivors of a prolonged rigorous educational process obviously demonstrating an outstanding attribute, the will and the stamina to endure.

Why would such a group so easily capitulate to socialism and governmental regulation? Why do the vast majority stand outside the political arena paralyzed into inactivity with the excuse, "There's nothing I can do about it." Are they too self-satisfied—don't they know the price of freedom is eternal vigilance —do they rationalize, "I'm too busy," when busy people find the time for activities they judge important?

Don't they see the fallacious economic basis of socialism—"everything for nothing?" Why do they elect politicians who promise utopia, and then irresponsibly pile debt upon debt with its inevitable devastating inflation and eventual economic crisis? Thirty years of prosperity structured on debt—the Federal debt at 700 billion dollars, social security system bankrupt, corporate debt at record levels, mortgage debt at all time highs, consumer debt at record levels. Have we lived since World War II, through the age of permissiveness, with loss of economic discipline, cajoled by utopian promises into believing there's no end to unlimited prosperity structured on debt? Where is our intelligence?

This is the age of power politics—of bloc politics. Why are we not more active in KMA? Why do only a handful support KEMPAC with its 90% success record in candidate support? Why are our county societies not focal points for involvement? Why do doctors only talk to doctors—why are not some speakers, labor leaders, public officials, businessmen, educators, or political candidates debating issues? Why is the enormous potential of the KMA Auxiliary allowed to lie dormant? Is there really nothing we can do—or have we become so narrow that we have lost our will to fight for our nation and our great heritage of freedom and liberty and individual responsibility?

JOHN P. STEWART, M.D.
KMA President

Letters to the Editor

The Letters To The Editor column is a means for the KMA physicians to express their opinions and viewpoints on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Letters To The Editor, Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Kentucky 40205. Communications should not exceed 250 words. The right to abstract or edit is reserved by the editors of *The Journal*. Names will be withheld upon request, but anonymous letters will not be accepted.

To the Editor:

The Adair County Medical Staff and the Adair Memorial Hospital (old hospital board) recently voted in separate sessions to oppose the EKHSA's Maternal and Infant Care Plan in which it is recommended that this type care be consolidated, and in our three county area, be provided only in Campbellsville. The Adair County District Board of Trustees (new hospital board) for the new 65 bed hospital plan to make their opposition official at their next meeting. We realize this is only a proposal, but we consider it to be a serious proposal.

Many of us feel that the plan as proposed is a threat to the private practice of medicine and to health care in rural areas. This idea of consolidation and regionalization could to some extent be considered a controversy between urban and rural areas. The American Academy of Family Physicians has increased residencies tremendously over the past few years and one of the greatest concerns of the nation has been rural health care and the maldistribution of physicians. A new Board Certified Family Physician has agreed to locate in Columbia. He is especially well trained and very interested in Obstetrics, and the new hospital plans which include an obstetrical department influenced his decision to locate here.

In an article in American Medical News, February 27, 1978, the American Medical Association warned that "the patient will be the one to suffer" if the guidelines for Health Planning are not substantially changed. They state "that the present approach HEW is taking is contrary to the needs and interest of patients." They state that guidelines "should be flexible, **not mandatory** to enable Health Systems Agencies to respond to unique local needs and resources." It also stated "there is no statutory basis for requiring state health plans to comply with national standards."

We adamantly oppose the plan's requirement of a number of deliveries annually to Level I facilities. There should be no number required. Adair Memorial Hospital can meet the criteria for Level I care and there would be no question as to the new 65 bed hospital meeting any requirements, unless a number of deliveries is imposed. Eligibility for Level I care should be based on standards or criteria for care and the necessary equipment. Mandatory requirements on the number of deliveries would undoubtedly have adverse effects on the availability of health care in small and rural communities. The AMA also noted and stressed "that there is nothing in the guidelines that would assure quality and equal access to medical care." It also said it is "improper to consider only economic issues at the expense of other factors."

The American Hospital Association has also voiced opposition to the revised HEW Health Planning Guidelines as stated in AMN, February 27, 1978. The AHA states that the plans, "still place undue emphasis on the objective of cost containment, slighting issues of access and quality. Health planning is not primarily a cost containment device." The guidelines as proposed are too heavy from the top and lacking in decisions at the grassroots level. "The correlation between quantity and quality is questionable in medical procedures and hospital services. Modernization of facilities, replacement of obsolete equipment, introduction of new techniques and above all educational programs ought to be expressly recognized as possible reasons for departure from the proposed national goals and benchmarks," AHA said.

Governor Carroll recommended to the recent Legislature the approval of the request for six and one half million dollars which was approved for regionalization of services. We do not support the fact that all this money will be spent on Level II and Level III centers. We felt that at least a small amount of this money should have been funnelled to the Level I centers. We have been told that if the next Legislature two years from now appropriates additional money we at the Level I centers might be included. But in the event money is appropriated again and the EKHSA requires a minimum number of deliveries for a Level I hospital, we could be denied funds for development and expansion. Therefore, we feel that the East Kentucky Health Systems Agency should do as the agency in West Kentucky and remove the minimum number of deliveries required to be an approved Level I hospital.

Millard C. Loy, M.D.
810 Jamestown Street
Columbia, Ky. 42728

To The Editor:

The always timely article concerning the difficulties of diagnosis of appendicitis, "Retrocecal Appendicitis" by Doctors Moss and West, p. 21, *Journal of the Kentucky Medical Association* for this month (January, 1978) should have pointed out the also little known fact that the anatomic location of the appendix is retrocecal in 64% of cases. Therefore, the "atypical" presentation of retrocecal appendicitis is always more common than expected, and indeed the classical presentation of appendicitis is more of a rarity.

David L. Harris, M.D.
Department of Surgery
Morehead Clinic
234 R Flemingsburg Road
Morehead, KY 40351

A Special Message

Dear Fellow Physician:

I am writing to you as Chairman of the Kentucky Medical Association Advisory Committee to Blue Cross and Blue Shield of Kentucky, Inc. Blue Cross and Blue Shield has recently acquainted me with two items that frequently cause problems in the proper administration of claim processing:

1. In-hospital consultations, and
2. Hospital Admissions for Consultations

I wish to take this opportunity to acquaint the entire membership of the Kentucky Medical Association with these situations and to explain them in more detail.

The first item (in-hospital consultations) is the problem of admitting patients to the hospital for consultation only. This means the patient is admitted to obtain a consultation which could have been obtained as an outpatient; then the consultant does not feel hospitalization was necessary. This represents unnecessary hospitalization, and many times, such claims are not paid under the existing Blue Cross and Blue Shield contracts. It should be emphasized that consultations should be obtained on an outpatient basis, thereby eliminating unnecessary hospital admissions and possible retroactive denials of such claims.

The second problem involves situations when the referring physician contacts a specialist and requests that a patient be admitted for consultation and evaluation. Many times the consultant follows through and hospitalizes the patient, only to find that all the necessary examinations could have been done on an outpatient basis. Indeed, hospital care was not necessary. Most Blue Cross and Blue Shield contracts will not pay for such hospital care. The consultant is then in the position of trying to justify a hospital stay that was not medically necessary.

The Advisory Committee of the Kentucky Medical Association of Blue Cross and Blue Shield of Kentucky, Inc. feels that these two conditions should be given proper consideration by all physicians in Kentucky so that their patients will not have to pay a large, unnecessary hospital bill as well as pay for the diagnostic studies which were done. A lot of money can be saved by having diagnostic testing done on an outpatient basis.

We are calling this matter to your attention to ask your cooperation in helping to reduce unnecessary hospital days and reduce to some degree the costs of providing medical care.

Sincerely,
E. S. Kimbel, M.D.
Chairman of Advisory Committee
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Report From KMA Cancer Committee——

The Subversion of Health Education by Advertising in Mass Media

A major role of every physician is the education of his patients to pursue personal practices that are in the best interest of their health. This responsibility is stressed by the very word "doctor" which is the Greek word for teacher. Yet, medical literature is replete with studies on the noncompliance of significant numbers of patients to our best efforts in health education. Nearly all these studies ignore the subversion of most health education objectives that occurs right in the patient's own home as well as at many critical points in his daily rounds—the advertisements in the mass media, often the very content of the written text of the media, and the program content of visual and auditory media. These advertising and programming techniques are generally directed at shaping consumer behavior, fostering the overconsumption of products and the pursuit of personal and group practices that are detrimental to health.

The techniques used are extremely well financed and most have been tested by research methods well known to behavioral and motivational scientists. The results of this extensive multimillion dollar research are rarely published and are often guarded as valuable trade secrets by owners. The techniques mold the behavior of the very young and hold this behavior in the adult by continued reinforcement. The resulting profits are enormous. Mass markets can be created and retained for totally new consumer industries very quickly and often before the effect of the products on human health are ever known. Against this media technology, most of the health education programs followed by physicians are painfully primitive and often totally ineffective.

Having identified the problem does not provide a solution. However, on a limited basis I have found that when it is pointed out to people just how badly they are being duped by advertising, they react in a very positive way, often drastically, of immunity against a disease, in this case the disease of behavioral subversion by advertising.

The basic purpose of this editorial is to recommend two very readable books that are exposés of the advertising industry so that physicians may enhance their own understanding of just how serious and adverse this problem is. These two books are entitled, *Subliminal Seduction* and *Media Sexploitation,* Signet Books, New American Library, Inc. 1301 Avenue of the Americas, New York, New York, 10019, both in paperback, written by William Bryan Key. They are often helpful to patients with overconsumption problems of all types since it gives them some insight into or "immunity" against the media forces that drive them to bad health practices.

With a primary interest in cancer, the fact has become increasingly obvious to me that most cancers are of behavioral origin and prevention will only be achieved as social practices and individual behavior are changed to less adverse patterns. The things every individual can do to reduce chances of developing cancer have been previously summarized in a short article written for lay readers, "Your Behavior and Cancer," which can be obtained from the Cancer Control Program, University of Louisville Cancer Center, P.O. Box 35260, 129 E. Broadway, Louisville, Kentucky 40232.

This article was written by John S. Spratt, Jr., M.S.P.H., M.D., American Cancer Society, Professor of Clinical Oncology and Deputy Director of Cancer Center, University of Louisville, Health Sciences Center.

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General—If irritation develops, discontinue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.

Usage in Pregnancy—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids—in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusive dressing increases the percutaneous absorption of corticosteroids. For patients with extensive lesions it may be preferable to use a sequential approach, occluding one portion of the body at a time. Keep the patient under close observation if treated with the occlusive technique over large areas and over a considerable period of time. Occasionally, a patient who has been on prolonged therapy, especially occlusive therapy, may develop symptoms of steroid withdrawal when the medication is stopped. Thermal homeostasis may be impaired if large areas of the body are covered. Discontinue use of the occlusive dressing if elevation of the body temperature occurs. Occasionally, a patient may develop a sensitivity reaction to a particular occlusive dressing material or adhesive and a substitute material may be necessary. If infection develops, discontinue the use of the occlusive dressing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, perioral dermatitis, allergic contact dermatitis, hypopigmentation, maceration of the skin, secondary infection, skin atrophy, striae, and miliaria.

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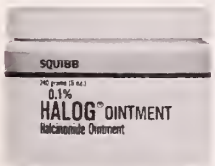

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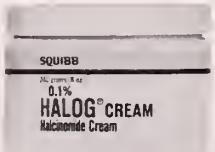

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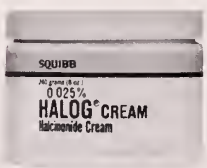

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Swan-Ganz® Catheterization—An Aid in Management of High Risk Obstetrical Patients

Joan C. Paust, M.D. and Mitta A. K. Reddy, M.D.

Louisville, Kentucky

Bedside pulmonary artery catheterization has been widely accepted in critical care medicine. It can be a useful aid in treating the seriously ill obstetric patient, particularly when toxemia is present.

SINCE its first description in 1970[1] Swan-Ganz® flow directed pulmonary artery catheterization has gained widespread use in medicine. It is now used both in the operating room and intensive care units for hemodynamic monitoring in the management of patients with marginal cardiovascular reserve, large blood or fluid losses, sepsis, respiratory failure responding to positive end expiratory pressure, active myocardial infarction, cardiac surgery, hypotensive anesthesia, and massive trauma. However, with rare exception, very ill obstetrical patients have not had such monitoring available to them.

In high risk obstetrical patients, Swan-Ganz® right heart catheterization can be useful in patients with cardiac disease, toxemia, abruptio placentae, septic shock, amniotic fluid embolism, and/or massive hemorrhage with or without disseminated intravascular coagulation. The following cases demonstrate its usefulness:

Case #1: R. F. was a 21-year-old white primigravida nurse who had a normal prenatal course until 24 weeks gestation when a blood pressure of 148/100, 3+ albuminuria, and 2+ pretibial edema were noted. She was admitted to a community hospital for evaluation and stabilization. She was initially treated with hydralazine and later methyldopa. Over the next four weeks her total serum proteins fell from 5.5 to 4.9 gm/100 ml, albumin from 2.8 to 2.3 gm/100 ml, creatinine clearance from 80 to 63 ml/minute. Her serum creatinine rose from 0.9 to 1.3 mg%, uric acid from 5.7 to 8.5 mg%, and BUN from 11 to 36 mg%. Ultrasound at 26 weeks gestation by dates, was consistent with 25 weeks size; at 28½ weeks by dates, the ultrasound was consistent with 26 weeks gestation. She was discharged with a blood pressure of 130/88 and referred to the regional high-risk perinatal unit. She was closely followed as an outpatient from the 27th through 30th week, at which time she was admitted for a blood pressure of 160/120 and 3+ albuminuria.

It was felt that the patient had primary progressive renal disease with superimposed hypertension and toxemia. On admission, BUN was 40 mg% and creatinine clearance was 53 ml/minute. On the second hospital day, at 30½ weeks gestation, the patient had two grand mal seizures while in the labor and delivery suite. These were treated with intravenous diazepam. Intravenous magnesium sulfate was begun. In view of a compound breech presentation and eclampsia, it was

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elected to deliver the patient by cesarean section as soon as she was stabilized. Because of her chronic low serum albumin and total proteins, probable primary renal disease and possible hypertensive heart disease, a Swan-Ganz[R] catheter was passed at bedside into the pulmonary artery from the right infraclavicular subclavian venous route using the Seldinger technique[2] with simultaneous electrocardiogram and pressure recording. Chest x-ray confirmed placement, showed **no** pneumothorax, but did show large bilateral pleural effusions with possible congestion. The patient was then taken to the operating room for cesarean section under general endotracheal anesthesia. Rapid delivery of an Apgar 4 (1 minute) and 7 (5 minutes) 750 gram viable male infant was accomplished.

The patient had 1500 cc of ascitic fluid in the abdomen at the time of cesarean section. A right open renal biopsy was done at this time. Pulmonary artery and capillary wedge pressures were used to monitor fluid replacement and cardiac status. Both parameters remained normal and the patient was not transfused. She received 700 cc of 5% Dextrose and 0.45% saline and was transferred to the intensive care unit where she was ventilated mechanically for two hours before extubation. The patient and infant had unremarkable postoperative courses. The placenta weighed 282 grams and showed changes consistent with toxemia, including one large and several small areas of infarction, edema, syncytial trophoblastic knots, and villous stromal proliferation. There was meconium staining and several areas of old hemorrhage. The kidney biopsy showed histologic changes consistent **only** with toxemia of pregnancy.

Case #2: A. B. was a 25-year-old married black gravida 2, para 1 patient who was admitted to the labor and delivery suite of the regional high-risk perinatal unit at 38½ weeks gestation following a completely uneventful prenatal course. Four years previously she had a vaginal delivery of a 6 lb 13 oz living male infant which was complicated only by a "prolonged labor." On admission the patient's blood pressure was 150/120, pulse 86, and she was having severe abdominal cramping which she described as "not right." There had been recent loss of fetal movement. Although the fetal heart was heard by a nurse and obstetric technician on admission, it could not be heard 10 minutes later. Examination by the obstetric resident noted the patient was 1 cm dilated, vertex presentation, at a −2 station. An intravenous infusion was started, initial blood work drawn, a Foley catheter inserted, and magnesium sulfate was begun intravenously. Initial laboratory results revealed a hemoglobin of 12.7 gm%, hematocrit of 40.2%, fibrinogen of 180 mg/100 ml, "adequate platelets" by estimate, and a normal prothrombin time and partial thromboplastin time.

Within a short time, the blood bank realized that the patient had atypical antibodies and could only be crossmatched with difficulty. Within five hours the blood pressure was down to 110/80, pulse 80, and membranes were ruptured artificially by the obstetrician yielding bloody fluid. The patient was 2-3 cm dilated and continued to have strong contractions every 1½ minutes without augmentation of labor. However, there had been no urine output despite an intake of 450 cc of 5% Dextrose and 0.45% saline. With administration of an additional 215 cc of intravenous fluid, the patient had 15 cc of urine output. Six hours after admission the hemoglobin was 11.9 gm%, hematocrit 36.8%, platelets 120,000, and fibrinogen 80 mg/100 ml. The blood bank and the American Red Cross continued to be unable to crossmatch blood. The cervix remained unchanged and the fibrinogen dropped to 64 mg/100 ml with fibrin/fibrinogen degradation products positive at a 1:20 dilution. A second peripheral intravenous infusion was started and rapid infusion of 5% Dextrose in lactated Ringers was begun. A central venous pressure line was placed in the right subclavian vein via the infraclavicular route and using a 14 gauge 5¼″ Angiocath[R]. Initial central venous pressure was −3 cm H_2O. The patient was eclamptic and diazepam was administered intravenously three times in the next two hours. She also received 5000 cc of 5% Dextrose in lactated Ringers, 34 units of cryoprecipitate, and one unit of fresh frozen plasma. Urine output increased to 290 cc in two hours. However, nine hours after admission the hemoglobin was 7.7 gm%, hematocrit 24.1%, platelets 75,000, central venous pressure −2 cm H_2O, and the cervix was unchanged. Fibrinogen rose to 175 mg/100 ml. One unit of blood was found to be a close crossmatch, and two other units were available, though not a good crossmatch. Platelets fell to 40,000 and the decision to deliver the patient by cesarean

section was made. This timing was influenced greatly by the scarcity of blood and the impossibility of platelet transfusion. The patient was given an additional 20 units of cryoprecipitate and a second unit of fresh frozen plasma. She was taken to the operating room for cesarean section under general endotracheal anesthesia. Central venous pressure was 8 cm H_2O, blood pressure ranged from 120 to 150 torr systolic over 75 to 100 torr diastolic with a pulse of 100. The three units of blood were given as washed packed cells. A stillborn 16½″, 3 lb 8 oz male infant was delivered and the completely abrupted placenta followed.

Meanwhile, type specific blood samples were drawn from hospital employees in hopes of finding reasonably compatible blood. Two employees did have blood which was a close crossmatch and their blood was collected, the red cells washed and packed, and the plasma refrigerated. Postoperatively, the patient was moved to the intensive care unit and placed on a Bennett MA-1[R] ventilator. She was in clinical pulmonary edema, and had serial central venous pressure readings of 15, 18, and 30 cm H_2O, in spite of treatment with furosamide, morphine, sodium bicarbonate, and deslanoside (Cedilanid[R]-D). It was felt that the pulmonary edema was due to **low** oncotic pressure with resultant fluid loss into the lungs, rather than heart failure. Therefore a Swan-Ganz[R] catheter was inserted into the right subclavian, using Seldinger[2] technique to replace the existing central venous pressure line. Initial pulmonary capillary wedge pressure was 12 torr, which confirmed the fact that the patient was **not** in heart failure, even though the central venous pressure was 30 cm H_2O. The patient was then given the two units of washed packed cells and her "pulmonary edema" disappeared. Pulmonary capillary wedge pressure ranged from 12 to 16 torr. Total serum proteins were 4.1 gm/100 ml and the two units of fresh refrigerated plasma were infused. Urinary output remained good, blood pressure was 170/90, pulse 100, hemoglobin 13.2 gm% and hematocrit 40.7%. The P_aO_2 remained low (56 torr with 0.8 FIO_2 and 5 cm positive end expiratory pressure). The patient was felt to have developed adult respiratory distress syndrome secondary to hypotension and/or transfusion incompatability. She was treated with antibiotics and corticosteroids. She was extubated in 48 hours. On the fourth postoperative day the patient was transferred to the transitional care unit. She was discharged from the hospital on the 19th postoperative day with residual inflammatory changes in the region of the lingula.

Case #3: J. C. was a 23-year-old white married gravida 2, para 1 woman admitted at 36 weeks gestation, with abdominal pain and "long lasting contractions." The first pregnancy was complicated by eclampsia and a 2½ lb premature infant which died after birth. This pregnancy had been followed at the regional high-risk center and had been completely uneventful until admission. The fetal heart could not be heard on admission and intrauterine demise was confirmed by internal fetal EKG monitoring. The patient's initial vital signs were blood pressure 130/80 and pulse 120; she was diaphoretic, shivering, and had a tense abdomen. The clinical impression was abruptio placenta. Initial hemoglobin was 11.0 gm%, hematocrit 34.2%, fibrinogen 0, and platelet count 205,000. She was given plasmanate and pitocin was started. Within an hour of admission her blood pressure was 150/90, she had 1+ albuminuria and 3+ hyperreflexia. Magnesium sulfate was started and 20 mg of furosamide was administered intravenously. Her hemoglobin dropped to 9.5 gm% with a hematocrit of 28.3% within five hours of admission. She had received 26 units of cryoprecipitate and two units of packed cells.

Laboratory tests for disseminated intravascular coagulation were now positive in both blood and urine. In view of the magnitude of the patient's coagulation defect and expected large blood loss at delivery, a Swan-Ganz® catheter was passed via the right subclavian vein. The pulmonary capillary wedge pressure was maintained between 8 and 13 torr during the intrapartum period. During this time other parameters, such as blood pressure, were of no use as a guide to therapy because of the toxemia present. Repeat blood work before delivery showed a fibrinogen of 112 mg/100/ml, platelets 105,000, and prolonged prothrombin and partial thromboplastin times. She received an additional eight units of fresh frozen plasma and six units of packed cells. Immediately after delivery the hemoglobin was 12.5 gm%, hematocrit 37.4%, fibrinogen 110 mg/100/ml, platelets 56,000, prothrombin and partial thromboplastin times prolonged, but blood gases, electrolytes, BUN, and glucose were normal.

As needed postpartum, the patient received an additional 12 units of cryoprecipitate and two units of fresh frozen plasma. Six hours after delivery her hemoglobin was 8.3 gm%, hematocrit 24.3%, fibrinogen 240 mg/100/ml, platelets 49,000, prothrombin and partial thromboplastin times normal, and electrolytes normal. The patient looked well and requested lunch. She received an additional six units of blood and was discharged on the fourth postpartum day with a hemoglobin of 12.1 gm% and a hematocrit of 36%.

Case #4: C. W. was a 16-year-old black primiparous patient who was admitted to the labor and delivery suite at term. She had a history of rheumatic heart disease with aortic stenosis, aortic insufficiency, possible pulmonic stenosis, and mild fluttering of the anterior mitral leaflet. She had been asymptomatic during her pregnancy except for dependent edema during the several days before admission. The patient initially had a blood pressure of 160/110, proteinuria, edema, and hyperreflexia. Magnesium sulfate was started and maintained intravenously at 1 gram per hour. Anesthesia consultation was sought when the patient became anuric and cephalopelvic disproportion was suspected. Labor pain was relieved with continuous lumbar epidural anesthesia via a catheter placed in the L2-3 interspace. A triple lumen 7 French Swan-Ganz® balloon-tipped flow-directed catheter was passed at bedside into the pulmonary artery via the right subclavian vein without difficulty. Portable chest x-ray confirmed position and ruled out pneumothorax. The initial right atrial pressure was 15 torr and the pulmonary capillary wedge pressure was 4 torr. The patient was given 500 cc of plasmanate and then 2 liters of lactated Ringers while both right atrial pressures and pulmonary capillary wedge pressures were monitored.

Five hours later, her right atrial pressure was 6 torr while the pulmonary capillary wedge pressure was 12 torr. The bood pressure was 169-170/90-110 and urine output was brisk. Since she had not progressed despite adequate augmentation and trial of labor, a cesarean section was done under epidural anesthesia with a level of T4 established by injecting 15 cc of 0.75% bupivicaine into the existing epidural catheter in place at the L2-3 interspace. The pulmonary capillary wedge pressure was maintained between 11 and 14 torr during the 1 hour and 5 minute procedure and there was 200 cc of urine output. Blood pressure fell to 130/80. The patient had an uneventful postoperative course.

Discussion

These cases illustrate the use of Swan-Ganz® right heart catheterization as an aid in the diagnosis and management of the seriously ill obstetrical patient. These flow-directed balloon-tipped catheters can be placed at bedside with electrocardiographic monitoring and continuous pressure recording as the catheter is passed. Monitors suitable for continuous electrocardiogram and pressure tracings are available that occupy less than one half cubic foot.

Access to the right heart can be via cutdown or various percutaneous techniques. The femoral, basilic, brachial, internal jugular, or subclavian veins are most commonly used to introduce the catheter. Use of the more peripheral veins usually lengthens the time needed to place the catheter, often necessitates a cutdown, and may require immobilization of the extremity. The internal jugular and subclavian veins are favored for rapid insertion using percutaneous introducers.[3] Right-sided veins are preferred. In the sick obstetrical patient, insertion is often complicated by the presence of significant edema and, not uncommonly, the infraclavicular subclavian route may be the best or only route readily accessible. It is important that subclavian venipuncture, especially in the face of impaired coagulation and potential hazard of hemothorax or pneumothorax, be done by the most experienced person available. As the catheter is passed through the right ventricle dysrhythmias may occur. Usually these are transient. Deflation of the balloon and withdrawal of the catheter temporarily will usually terminate such dysrhythmias, but occasionally intravenous administration of a 50 to 100 mg bolus of lidocaine may be needed.

Once the catheter is in place in the pulmonary artery so that the pulmonary capillary wedge pressure can be measured, the data obtained is clinically valuable in evaluating pulmonary congestion and left atrial filling which can serve as an index of left ventricular filling pressure and overall left ventricular function.[3] Depending on the catheter used, various measurements can be made. The basic double lumen catheter is used to measure pulmonary artery pressure and pulmonary capillary wedge pressure. The triple lumen catheter has the additional capability of measuring right atrial pressure. The double lumen and

triple lumen catheters can also be used to obtain blood samples or for infusion. Other types of catheters can be used for measuring cardiac output by thermodilution or can be modified for continuous readout of oxyhemoglobin saturation by fiberoptic means. There are also non-monitoring flow-directed balloon catheters available for bipolar cardiac pacing and pulmonary angiography.

Indications for Swan-Ganz® right heart catheterization in the obstetric patient include: management of the cardiac patient (rheumatic disease, congenital defect, or marginal cardiovascular reserve of any etiology), shock (septic or hypovolemic—actual or anticipated), severe toxemia, low oncotic pressure, impaired renal function, pulmonary thromboembolism, amniotic fluid embolism, pulmonary hypertension, and pulmonary disease (adult respiratory distress syndrome, severe pneumonia) especially that requiring ventilatory assistance.

Potential complications include those of the particular catheter entrance site plus dysrhythmias, thrombosis around the catheter, phlebitis, pulmonary infarction, pulmonary artery or right atrial trauma, knotting of catheter, balloon rupture, air emboli, infection, and kinking of catheter leading to inability to deflate balloon.[3]

Since its introduction in 1970, Swan-Ganz® flow-directed pulmonary artery catheterization has gained widespread use in the diagnosis and management of seriously ill patients in the operating room and intensive care units. The seriously ill obstetric patient can also benefit from this tool as illustrated in the cases presented.

The catheter can be placed at bedside without interruption of electronic fetal monitoring or therapeutic measures. Small portable equipment allows maternal monitoring to continue in the delivery room and postpartum.

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Operative Localization of the Suspicious Lesion on Mammography

James P. Moss, M.D., and R. G. Voyles, M.D.

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Mammography is able to detect suspicious breast changes which are not palpable on examination. Past management has often consisted of a "generous biopsy" in an effort to encompass the lesion. Surgical procedures have evolved in an effort to provide better localization, an accurate biopsy and less deformity. A technique is presented utilizing single needle placement and spot localization with methylene blue as a refinement of previously reported methods.

THE last two decades have witnessed concentrated efforts to improve the survival of patients with carcinoma of the breast. Extended surgery, chemotherapy, immunotherapy and receptor site determination have raised expectations which remain statistically unfulfilled. The most rewarding clinical advances against this disease in recent years have been the result of efforts for earlier detection through public education, self-examination, and improved screening techniques and programs.

Mammography has received widespread acceptance since its introduction by Egan 15 years ago. Eighty percent of patients with a breast cancer detectable only by mammography are free of axillary metastases.[1,2] With improved prospects for survival, the necessity for the precise localization of the nonpalpable lesion is apparent but may present considerable difficulty. In the past, "generous" biopsies have been performed in an effort to encompass the lesion. While the surgeon must be aggressive in order to assure an adequate biopsy, he should also attempt to minimize deformity because 75% of radiographically suspicious foci are benign.[1,3] A method to improve operative localization of these nonpalpable lesions is presented.

Methodology

Immediately prior to biopsy, the patient is transferred to the x-ray Department. There the radiologist inserts a single 21 gauge needle so that its tip lies in proximity to the suspicious area. Lateral and craniocaudal mammograms are then taken to confirm the relative location of the suspicious lesion (Fig. 1, Fig. 2). After the needle is firmly secured with tape, the patient is transferred to the Operating Room.

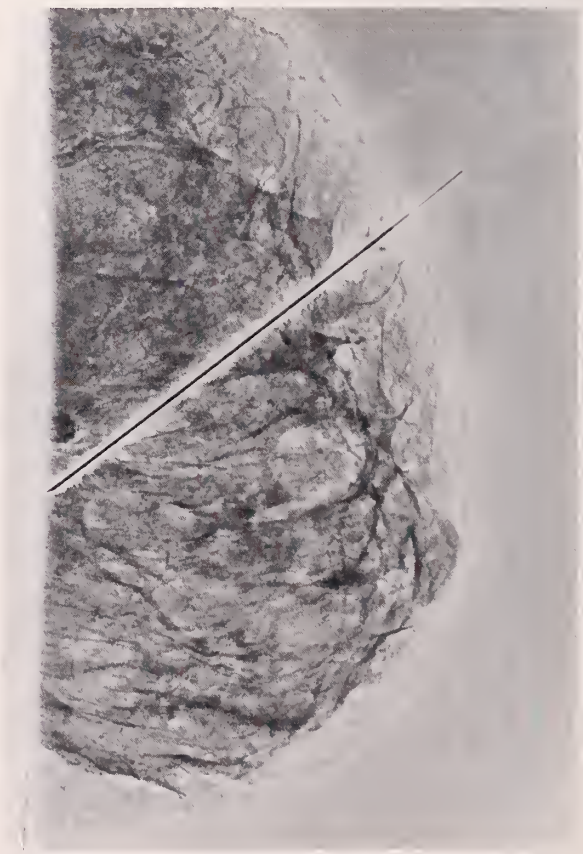

Fig. 1: Lateral mammogram taken preoperatively demonstrating suspicious lesion just above the tip of the needle.

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Fig. II: Craniocaudal mammogram with the lesion medial to the needle.

Fig. III: Mammogram of the surgical specimen confirms excision of the suspicious lesion.

Before the skin is prepared for surgery 0.3 ml of methylene blue is injected through the needle. The biopsy is then performed using the methylene blue and the needle tip as landmarks. Xeromammograms of the specimen are then obtained to confirm the presence of the lesion (Fig. 3).

Discussion

One-third of breast cancers detected by large screening programs are found by mammography *only*.[2] For the nonpalpable lesion a blind generous biopsy offers less than optimal accuracy and may result in unnecessary deformity for benign disease.

Noninvasive localization procedures using skin markers and coordinates based on mammographic findings lack accuracy, especially in larger breasts. Needle localization—using one, two or three needles—has been discussed in previous reports.[4,5] One well-directed needle offers the accuracy of two or more and allows mammography to be performed in a less cumbersome fashion. Methylene blue is injected for two reasons: to mark the needle point should displacement inadvertently occur during skin preparation and to facilitate intraoperative localization of the needle tip. Others have relied solely on the methylene blue injection for localization and have removed the needle prior to biopsy.[6] Some have attempted to mark the needle tract to the lesion with methylene blue. The limitations for these uses of methylene blue are related primarily to its rapid and unequal dispersion in the breast tissue.

It has been suggested that more accurate localization can be obtained by means of a small hooked wire inserted through a 25 gauge needle.[7] The self-retaining feature of the technique is attractive but the tip of the pliable wire is difficult to palpate in dense breast tissue during surgery. The production of a needle with a small barb on the end may offer advantages over present techniques.

Upon completion of the biopsy, specimen radiography is performed on calcified lesions. Since the pattern of calcifications in the surgical specimen will be compared to the preoperative mammogram, it is important that this pattern be disturbed as little as possible. Certain authors have recommended that once the specimen is removed, it should be bisected or cut into multiple portions as an aid to the pathologist before x-rays of the specimen are taken.[5,8] This practice is to be condemned because it may disturb the pattern of calcifications, making comparison with the preoperative films impossible.

Although mammography is an effective tool in the diagnosis and management of breast carcinoma, it has certain limitations. In a recent review of one screening program, 77 occult breast cancers were demonstrated by mammography ONLY. However, in the same group of screened patients, 118 patients with suspicious masses on physical exam but with normal mammograms had biopsy-proven cancer.[1] A palpable suspicious mass with normal mammography must be biopsied.

As a result of advances in screening procedures, localization techniques for the nonpalpable breast lesion have evolved. The technique presented,

utilizing single needle placement and spot localization with methylene blue, is offered as a refinement of previously reported methods. Optimal results are obtained only when the surgeon carefully coordinates his efforts with those of the radiologist and pathologist.

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G. I. Hemorrhage With Candidiasis

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Two patients died with spontaneous upper G.I. bleeding caused by ulcerative candidiasis. Focal, stress-type ulcers developed in the stomach of one patient, while the second patient had a more typical diffuse esophageal ulceration. An element of portal hypertension is proposed as inducing the massive bleeding in the esophageal case.

SEARCH of the current literature on G.I. tract candidiasis failed to turn up specific cases associated with fatal bleeding. Doby has reported two cases, with colonic candidiasis, one of which developed massive rectal bleeding requiring emergency colectomy.[1] We recently encountered two patients dying of massive upper G.I. hemorrhage of unestablished cause. The autopsies revealed both cases to be associated with invasive candidiasis. We are confident that due to the emerging patterns of candidiasis in the compromized host,[2,3] similar cases must be occurring elsewhere but as yet unreported.

Case Reports

CASE #1. A 72-year-old coal miner entered the hospital with a long standing history of arrested, cavitary pulmonary tuberculosis and chronic obstructive lung disease, which had been treated with steroids. Following admission, he suddenly developed massive upper G.I. bleeding requiring several transfusions. Upper G.I. series showed only a slight duodenal bulb deformity. Gastroscopy showed multiple stress-type ulcers. He was then operated and a vagotomy and pyloroplasty done empirically. On the 6th hospital day he expired upon further bleeding.

The autopsy confirmed the persistence of multiple "stress-type" ulcers of the mucosa of the proximal stomach. The lumen contained about 1000 cc of blood and clots. No cultures of the ulcers were taken; however, histological exam showed focal acute areas of mucosal necrosis with deposits of invading budding yeast forms and hyphae (Fig. 1). Stains of the lung tissues were negative for fungi.

CASE #2. A 63-year-old white female had been surgically explored for non-operable carcinoma of the head of the pancreas two years previously. She entered the hospital for terminal care with evidence of massive jaundice and liver enlargement and expired shortly thereafter from massive upper G.I. bleeding. She had received only pain medication in the interim and had received no antibiotics, steroids, or chemotherapeutic agents.

The autopsy disclosed papillary adenocarcinoma of the ampulla of Vater with extension into head of the pancreas and massive metastases to the liver. There was no appreciable duodenal ulceration. The entire esophageal mucosal surface

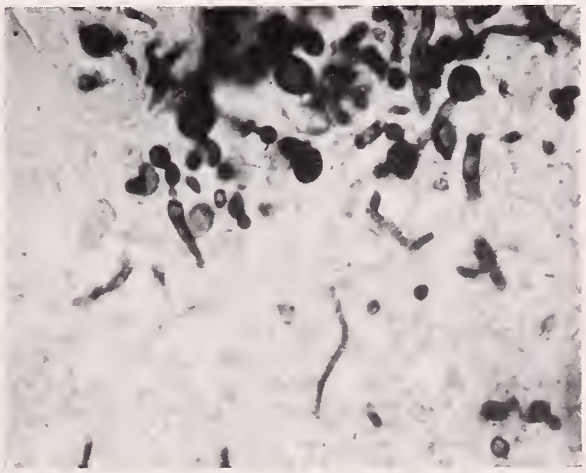

Fig. 1. Case #1. Budding yeast and hyphae noted in the base of the ulcers. Methenamine Silver Stain (Gomori's). X 780 (oil).

Doctor Miller is from the Department of Pathology, Doctor Diaz from the Department of Surgery, and Doctors Winkler and Brockman from the Department of Medicine at the Muhlenberg Community Hospital, Greenville, Kentucky.
Reprint requests to Doctor Miller.
Received at KMA 4-17-78.

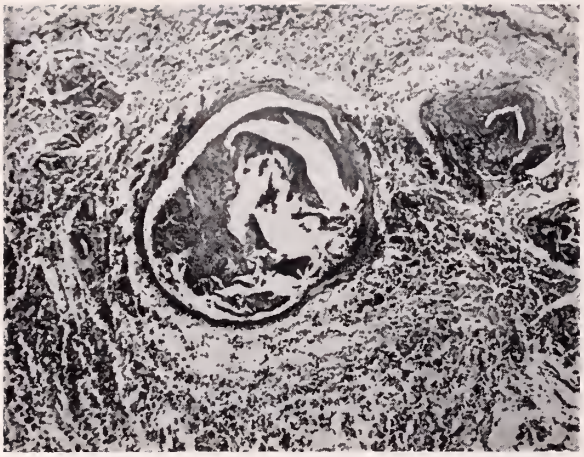

Fig. 2. Case #2. Prominent varices in the submucosa, some of which were recently thrombosed. PAS Stain. X 75.

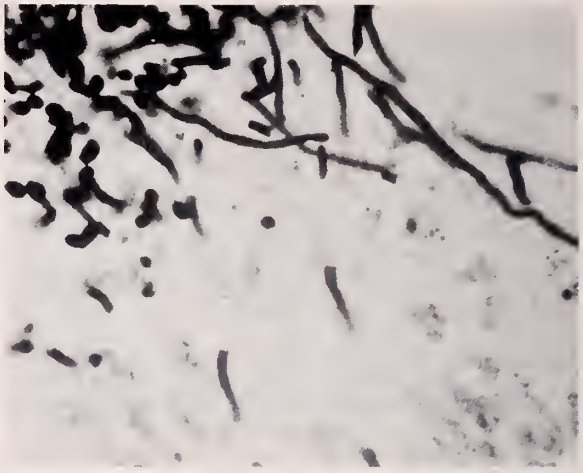

Fig. 3. Case #2. Budding yeast and hyphal forms found both superficial and deep in the areas of mucosal necrosis. Methenamine Silver Stain (Gomori's). X 780 (oil).

was blackened and hemorrhagic from the pharynx down to the stomach and had a typical "burnt appearance." The stomach contained about 1000 CC of liquid and clotted blood residua with lesser amounts of blood filling the remaining small bowel. Microscopic sections of the esophagus showed prominent varices, some of which were thrombosed. There were diffuse areas of superficial necrosis and slough with scattered deposits of infiltrating yeast and hyphae (Figs. 2 and 3). Fungi were not identified elsewhere in the body.

Comment

Candidiasis in its various forms is well documented in the healthy patient as well as the compromised patient.[4,5] Its exact pathogenesis in bowel lesions is incompletely understood. The gut-reservoir concept would indicate the presence of the organism in the bowel in healthy as well as diseased hosts.[6,7] Being opportunistic, the organisms easily colonize an area of the bowel having altered flora or decreased defense mechanisms.

Concerning the factors underlying massive bleeding, different factors would probably pertain, depending on the location of the lesion. Acute or active ulceration of the gastric mucosa, whatever the cause, usually leads to hemorrhage of variable degree. On the other hand, the characteristic diffuse hemorrhagic and ulcerative lesion of monilial esophagitis seldom alone produces significant bleeding. The explanation for the usual lack of significant bleeding probably lies in the histopathologic nature of the lesion which shows in addition to extensive necrosis, ulceration, and some interstitial hemorrhage, thrombosis of mucosal and submucosal vessels. Consequently there is minimal loss of blood from such exposed vessels.

An added feature of Case #2 was the element of portal hypertension. Mucosal ulceration superimposed on esophageal varices would certainly be sufficient lesion to promote the occurrence of profuse bleeding.

The true nature of the hemorrhage in both cases was not suspected prior to death. Obviously, studies including barium swallow, esophagogastroscopy, and fluid aspiration for culture and smear, would appear to be the only way to alter a fatal outcome for these patients. First, however must come a high index of suspicion for the diagnosis.

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GRAND ROUNDS

University of Kentucky College of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

Rectal Prolaspe: A Brief Review

Rectal prolapse, defined as protrusion of part or all of the layers of the rectum through the external anal sphincter, is an uncommon condition. Clinically, rectal prolapse is associated with fecal incontinence with continual fecal soilage, perineal excoriation, discomfort and social embarrassment. The diagnosis is established by observing the prolapse and is usually obvious especially following a bowel movement.

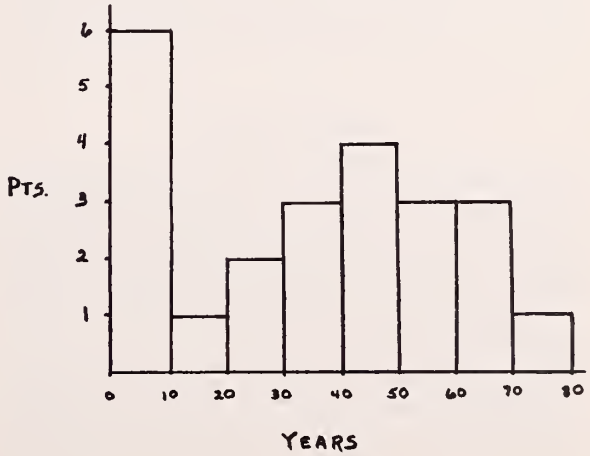
Rectal prolapse is seen most often at the extremes of age with 50% of patients under three years or over 60 years of age.[1,2-4,23] In most series women are found to have a prolapse twice as commonly as men. This increased incidence in women has often been attributed to disruption of the perineal floor by childbirth, but this has not been supported by the most recent large series reported. Altemeier has noted a high incidence (83%) of neuropsychiatric disease in his patients with prolapse and suggests that poor bowel habits, especially constipation, may play an etiologic role in the development of prolapse.[3]

Our experience with rectal prolapse patients differs only slightly from reports of other centers. From January 1968 to March 1978, there have been 23 patients with rectal prolapse treated at the University of Kentucky. Their ages ranged from newborn to 75 years and the ratio of females to males was one-to-one (Fig. 1). Only one case of prolapse was thought to be associated with childbirth, while five patients (22%) had a neuropsychiatric disorder. The conditions associated with prolapse from our series are summarized in Table 1.

While there is some unaminity as to the clinical characteristics of patients with prolapse, there is considerable controversy over the pathophysiology of the lesion. On one side of the question it has been claimed that rectal prolapse is in reality a perineal hernia. This hernia is thought to be due to a defect in the perineal floor which allows the rectum to descend as a perineal sliding hernia. This view of prolapse as a sliding hernia is supported by the anatomic dissections of Graham, Dunphy, Altemeier, and others.[1,2-4,8,12] A contrary view of prolapse as a rectal intussception is espoused by Theurkauf, Ripstein, and others.[20-22,24] In a cine-radiographic study, Theurkauf demonstrated very clearly that there was an intussception of the rectum associated with prolapse in several of his patients.[24]

Probably both views of rectal prolapse are correct and represent stages in the development of prolapse. In the older literature, protrusion of the rectum was divided into rectal prolapse (meaning only mucosal descent) while the term rectal procidentia was reserved for descent of all layers of the rectum, yet both situations were referred to generically as rectal prolapse.[23] More recently, Altemeier has classified rectal prolapse into there types: Type 1 (False Prolapse), protrusion of the mucosa only; Type 2 (Incomplete Prolapse), protrusion of all layers of the rectum through the anal sphincter as a rectal intussception; and Type 3 (True or Complete Prolapse), protrusion of all layers of the rectum and descent of the cul-de-sac so that a sliding hernia occurs[1-4] (Fig. 2). This classification seems to

FIGURE 1



From the Department of Surgery, University of Kentucky Medical Center, Lexington, Kentucky.

Table 1

ASSOCIATED CONDITIONS IN 23 PATIENTS WITH RECTAL PROLAPSE

Anal Atresia (S/P Pull Thru)	−2
Ascaris Infestation	−1
Meningomyelocele	−1
Cystic Fibrosis	−1
Anal Stenosis	−1
Bleeding Hemorrhoids	−3
Childbirth	−1
Mental Retardation	−4

avoid the arbitrary and often confusing distinction between prolapse and procidentia. Altemeier's classification also seems to reconcile the elegant cine-radiographic studies of Theurkauf with the careful anatomic studies of others so that prolapse can be viewed as a continuum from redundant mucosa to the extreme of a sliding perineal hernia. What cannot be reconciled, however, is the cause of prolapse (i.e., whether the perineal weakness leads to prolapse or whether intussception causes the perineal weakness).

The controversy over the anatomic characteristics of rectal prolapse is more than matched by the diversity of surgical approaches to the repair of prolapse. In 1949, Wright was able to collect 51 different procedures for prolapse published since Moschowitz's original article in 1912.[18,25] The last 25 years have seen a continuation of surgical creativity directed at the repair of prolapse.

A variety of management approaches have been used for the 23 patients treated for rectal prolapse at the University of Kentucky over the past 10 years. Thirteen patients with Type 1 prolapse were treated without operation, twelve were managed with stool softeners and bowel training, and one infant with anal stenosis was managed successfully with rectal dilatation. Anoplasty and mucosal plication were employed in two patients with Type 1 prolapse. Of the eight patients who had a massive prolapse (Type 2 or 3), four underwent a trans-sacral repair of the perineal floor with fixation of the rectum to the sacrum. The procedures used are summarized in Table 2.

The choice of operation often depends on the status of the patient. Since many of these patients have associated neuropsychiatric diseases, major abdominal procedures which may pose significant management problems in the post-operative periods are not desirable. A recent case outlines an approach to the difficult patient.

Report of a Case

A 30-year-old severely retarded, white, female had protrusion of bowel mucosa 14-16 cm through the anal sphincter for three months. The prolapse was prominent following defecation and was associated with pain and bleeding. Medical consultation was sought by her institutional custodians because of increasing difficulty with manual reduction of the prolapse and deteriorating fecal continence.

The physical exam of this patient was carried out with difficulty since her activity ranged from restlessness to combativeness. The rectal sphincter was patulous and the prolapse was not obvious at rest. When she was re-examined following a bowel movement, the prolapsed bowel with friable mucosa was seen to protrude approximately 16 cm through the external sphincter.

The morning following admission she underwent a one-stage perineal repair of her rectal prolapse as described by Altemeier[1] under general anesthesia. Immediately post-operatively the patient was very combative and would not tolerate an intravenous infusion. She was begun on clear liquids the evening of operation and rapidly progressed to a regular diet the following day. By the fifth post-operative day she was noted to have formed bowel movements, evidence of good wound healing and was returned to institutional care.

Surgical repairs of rectal prolapse are directed at the anatomic changes perceived to accompany the prolapse which include: (1) a defect in the pelvic floor with diastasis of the levatores ani and a weakened endopelvic fascia; (2) loss of the normal horizontal position of the rectum due to its loose attachment of the sacrum and the pelvic walls; (3) an abnormally deep cul-de-sac of Douglas; (4) redundant rectosigmoid; and (5) a patulous or weak anal sphincter. Operative procedures which deal with these anatomic changes seem to accomplish satisfactory repair of the rectal prolapse in the majority of patients, but no procedure has been found to be totally satisfactory for all patients.

The surgical approaches to repair of rectal prolapse can be succintly summarized as repair from below, repair from above, resection and combinations. Five types of procedures seem to have contemporary application and merit consideration, based on the extent of the prolapse and the general condition of the patient:

(1) **Thiersch Wire:** The Thiersch wire technique consists of passing a heavy gauge wire in the subcutaneous tissue outside the rectal sphincter to surround the patulous anus associated with prolapse.[6,26] The wire is then tightened down against an obturator to achieve the appropriate size of the anus and thereby prevent prolapse. Utilization of the Thiersch wire carries the hazards of fecal impaction and recurrence of prolapse in a high percentage of patients. The wire can be inserted under local anesthesia and has essentially no operative morbidity, factors which recommend its use in the very elderly and infirm patient for whom a temporizing procedure may be all that is required.

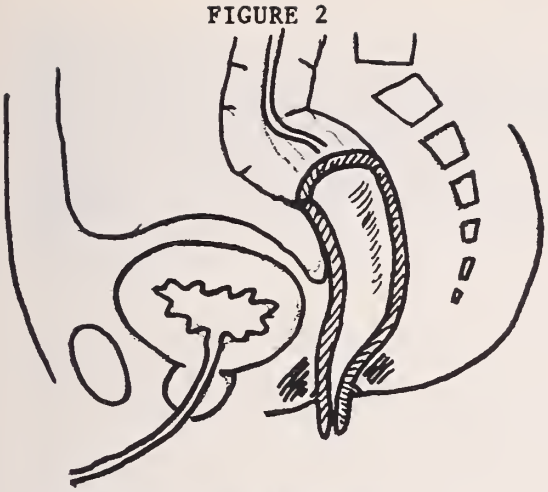
(2) **Altemeier One-Stage Perineal Approach:** Altemeier has reported on an extensive long-term experience using his perineal approach to prolapse.[1-4] This procedure attacks three of the five anatomic changes associated with

Table 2

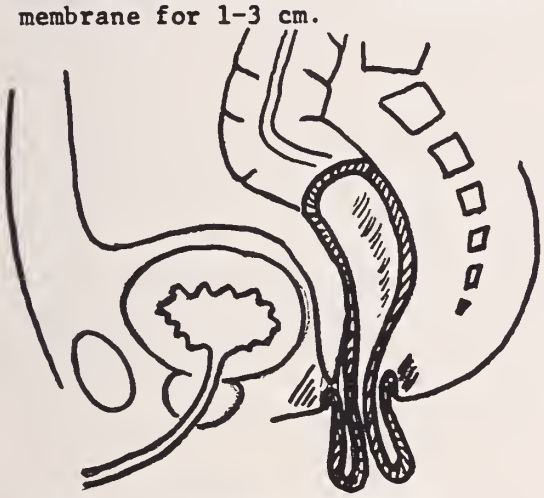
TREATMENT OF RECTAL PROLAPSE

Type 1	
No Operation	12
Rectal Dilation	1
Anoplasty	1
Sphincterotomy	1
Types 2 and 3	
Trans-sacral Fixation and Perineal Repair	3
Trans-sacral Resection	1
Trans-abdominal Suspension	1
Rectal Plication	2
One-stage Perineal Repair	1

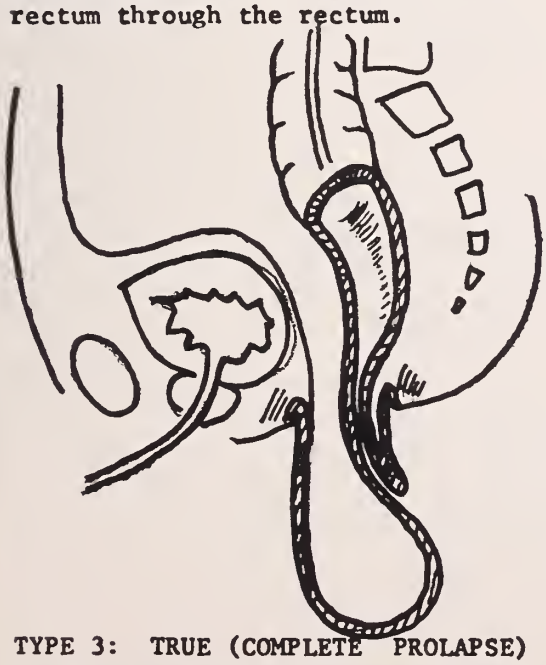
FIGURE 2



TYPE 1: FALSE PROLAPSE
Protrusion of a redundant, hypertrophied and abnormally loose mucous membrane for 1-3 cm.



TYPE 2: INCOMPLETE PROLAPSE
Protrusion of all layers of the rectum through the rectum.



TYPE 3: TRUE (COMPLETE PROLAPSE)
A perineal sliding hernia through the perineum of the cul-de-sac.

prolapse. First, the prolapsed redundant bowel is resected, then the sliding perineal hernia component of the complete prolapse is repaired by obliterating the hernia sac. Finally, the perineal floor is reconstructed by approximation of the levator ani muscles to the midline anterior to the rectum. This procedure does require an anesthetic, either general or spinal, but does avoid an abdominal incision so that it can be used in the poor risk patient.

(3) **Suspension Procedure:** Suspension procedures attempt to repair the prolapse by fixing the rectosigmoid to the posterior peritoneal cavity so that it can not descend through the anus. A wide variety of techniques have been proposed to accomplish this, including direct suture of the rectosigmoid to the psoas or sacral fascia and suspension of the rectosigmoid by fascial or prosthetic slings.[5,17,19,20-22] Ripstein originally reported in 1952 the use of a fascial sling to fix the rectum to the hollow of the sacrum. More recently he and others have modified his technique using a Telfon mesh sling.[20-22] The principal complications of this procedure are fecal incontinence and impaction. Other principles of repair may be added to the suspension procedures, including obliteration of the clu-de-sac and reconstruction of the perineal floor.[11,16,18] Suspension or fixation can be carried out either trans-abdominally or by a trans-sacral approach.[7]

(4) **Resections:** Prevention of rectal prolapse can also be accomplished by resection of the redundant recto-sigmoid.[9,10,15,24] This can be done trans-abdominally as a low anterior resection or by a trans-sacral approach.[7,13] The success of the resection procedures may be due as much to scar fixation of the recto-sigmoid in the planes of dissection as to excision of the redundant bowel. As with other approaches perineal repair can be carried out with the resection.

(5) **The Abdomino-perineal approach of Dunphy:** This procedure is carried out in two stages, with the first consisting of the perineal approach of Altemeier.[1,2-4,8,14] Several days later an abdominal procedure is carried out to fix the rectum to the hollow of the sacrum and to obliterate the cul-de-sac from within the peritoneal cavity. This combined approach represents the most comprehensive technique for the management of prolapse, but unfortunately it also is a major surgical undertaking, and has not been demonstrated to be superior to the other one-stage procedures.

Comments on the Case

This patient represented a management dilemma because of her aggressive behavior and retardation. Trans-abdominal or trans-sacral repair of her prolapse was not considered acceptable because of the anticipated management difficulties in the postoperative periods. The perineal approach was selected because it could be carried out with minimal morbidity and mortality and would require minimal patient cooperation in order to achieve success. It should also be noted that admission for operation was delayed until 24-hour, special one-on-one care could be provided.

Summary

Although the pathophysiology of rectal prolapse has not been completely defined, there are a number of management alternatives. Careful matching of the operative procedure to the type of prolapse and to the status of the patient should yield a high percentage of satisfactory results.

AUBREY L. ARMSTRONG, M.D.
BRACK A. BIVINS, M.D.
CHARLES R. SACHATELLO, M.D.

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EDITORIAL

Physicians, Patients, and the "Time Crunch"

"He met me in the hall as the nurse was taking me back to the examining room and looked at me and told me I was O.K. and to come back in two weeks to have the cast off. I never got to say a word to him."

or

"He just walked in the room, poked on my stomach, mumbled something about 'maybe tomorrow' and left. I thought he was coming back. . . ."

The amount of time to spend with a patient was surely a concern to Hippocrates and to every healer since. Some sufferers need a minute or less, others an hour or more, depending on things such as the patient's illness and personality and the doctor's specialty and personality.

There is a good solid streak of compulsivity present in most physicians. This is as it should be. The proper practice of medicine requires a meticulous quality, an attention to detail, an awareness of time and timeliness.

It is in this matter of time where many of us have special problems. With our compulsive natures we schedule our day fully and tightly. We don't really schedule it improperly. We allow just enough time to get absolutely everything done, provided nothing unexpected happens. But unexpected things *always* happen and our schedules begin to come apart. A friend asks that we see someone stat, phone calls intervene, honest emergencies happen. So we manipulate and struggle to keep up, skipping something, postponing a call, hoping someone will cancel something.

The physician is victim here, but so is the patient who gets caught up in our time crunch. Thoughtless patients cause part of the time problem, but basically we have to take responsibility for how we use our time and a major problem, as patients will quickly tell us, is the meager time we spend with them.

Of course, we cannot mass-produce good medical care. The bureaucrats will eventually find this out. When we are not always efficient, we can properly defend this on the basis of higher quality, an individualized approach—but only if we take enough time to make this credible to our patients and ourselves.

In the final analysis, the thing we and our patients treasure most is the one-to-one contact, the chance to hear and be heard, the interaction of two humans. Rush a patient through in less time than he actually needs and we create disappointment and build disloyalty and resentment.

Just now, we don't need that.

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SPECIAL ARTICLES

The Physician Alcoholic
ARCH To Recovery

Perry R. Ayres, M.D.

I remember Mike as an outgoing, white-haired, apple-cheeked man with a boyish grin. Although we were not close friends, our paths crossed frequently, and I always felt comfortable with him. Well-trained in medicine, he kept up with current developments, served willingly and well on many hospital committees, held offices in our Academy of Medicine, and was often involved in community health activities. He had a large following of devoted patients whom he served in the best traditions of family practice. Mike was born and raised in our community, and he had a host of friends, but his social life was quiet. He was a devout Catholic and a family man who enjoyed attending church affairs with his wife and their several children. He was very well thought of by one and all.

Mike died when he was about 50 years old and was buried with quiet ceremony. There was no public announcement of the cause of death. Some time later, however, we were shocked to learn that he was alcoholic and had died of barbiturate overdose, possibly suicidal. Only then did bits and pieces of information from the last year or two begin to have meaning. I had seen very little of Mike for several months before he died. On a few brief encounters, he had seemed tired and less ebullient than usual and had fussed uncharacteristically about the stresses of his practice. He had failed to show up for several meetings and had declined a couple of committee assignments. There had been rumors that one of his sons was having adjustment problems, and his favorite daughter was entering a convent. His previously slender, vivacious wife had gained a lot of weight and appeared anxious and depressed. Some of his old patients complained of difficulty in reaching him and of his curt behavior. Much later, a nurse told of an unintelligible, nocturnal conversation with him when she called to verify an order. In retrospect, it was clear that Mike had been in serious trouble for many months. We learned that he had neither sought nor been offered assistance by his colleagues—and we were very sad.

Now, I don't know why Mike was alcoholic, but I do know that he was not a "bad" man. He was a sick man, and his sickness had profound effects upon those nearest and dearest to him and carried the potential for danger to his patients. Compounding the tragedy is the sad fact that neither he nor we could recognize the clues to his illness that are so clear in retrospect. Had it been otherwise, this fine man might have been offered treatment.

Mike's story is a composite of several physicians I have known or attended. It might have been about meperidine, barbiturate, or amphetamine addiction, or some combination of these. Perhaps it should have included, "I know I've got a problem, but I like my problem," a statement recently made to his distraught wife by a prominent colleague who is still courting disaster with alcohol and amphetamines. It might have been the story of a young man whose drug abuse began while he was in medical school and continued for years before disaster struck. It might have been about the anesthesiologist, who combined her medical career with that of wife and mother until her alcoholism destroyed both careers. Or about the small-town practitioner, whose colleagues, in the pressure of their own busy lives,

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Doctor Ayres, a Columbus, Ohio, internist, is a former editor of the Ohio State Medical Journal. *This article is reprinted from the November 1977 issue of that Journal, Volume 73, No. 11.*

covered for him during frequent unexplained absences thus, unwittingly enabling his addiction to progress. Or the pathologist functioning well in his hospital job by day, who drank himself into a stupor in the seclusion of his study every night for years, and whose problem surfaced only after his wife suffered a psychotic breakdown. The futile efforts of family and colleagues might have been mentioned as in the case of the unemployed and unemployable industrial physician, whose wasted and scarred body was found in a motel surrounded by an assortment of syringes, bottles, and vials after he disappeared from a hospital during his 12th admission for problems related to his addiction.

Mike's story could have included a confrontation by a committee of concerned colleagues, apprising him of his difficulty and urging that he seek treatment. Or, it might have included a confrontation followed by kind-but-firm insistence that he take a leave of absence from his practice, undertake a prescribed program of treatment and rehabilitation, and then seek permission to resume practice. Just possibly, the ending might have been a happy one.

Industrial alcoholism programs feature just such confrontation. Employees are apprised of their work records and are then given firmly limited options—be fired or seek treatment. Large numbers of valuable employees are being salvaged, not to mention benefits in terms of morbidity, mortality, and quality of the lives of employees and their families.

Several state medical societies[1,2] have launched ambitious programs for dealing with physicians impaired by addiction by alcohol and other drugs. Their aim is to protect his patients and himself while the physician seeks treatment and proves he is stable. Such programs can and must work, and the scope of their activities will enlarge as they prove effective.

Volunteers performing the field work of the programs need talents of a sort that are difficult to teach—empathy, wisdom, patience, and faith. They especially need the wholehearted support of their colleagues. It is time that every physician takes a fresh look at the problem of the impaired physician and start by re-examining his attitudes, for it has been said that "the attitude is the father of the action."[3]

ARCH

Performance of a physician can be impaired by many things—by senility, by ineptitude, by incompetence, by dishonesty, for example, but those accessible to treatment are psychiatric disorders, drug addiction, and alcoholism. It is the latter two that are mentioned most often, and it is the alcoholic physician who is most readily identified. The remainder of this paper will be limited to consideration of some principles and attitudes I consider essential to the treatment of alcoholic patients, although some have wider application. They are represented by the acronym **ARCH** for **Acceptance, Recognition, Confrontation,** and **Hope.**

Acceptance of the concept that alcoholism is a treatable disease does not come easily to some physicians. Although practical experience of Alcoholics Anonymous and of alcoholism rehabilitation facilities teaches us that acceptance of the disease concept by both patient and therapist is a major factor in restoring patients to sobriety and to function, there have been two major obstacles for many physicians. First is the traditional moralistic stance, which says "while man may be the victim of his vices, he is also their author."[4] No doubt. But this begs the issue. While it may say something about drinking, it says little about alcoholism or about the fact that only about 10% of Americans who drink develop "preoccupation with alcohol," as described in the American Medical Association definition,[5] and follow a fairly predictable course in terms of compulsion, progression, relapse, and unmanageability of their lives. The alcoholic patient is a *sick* man trying to get **well,** not a **bad** man trying to get **good.**

The other stumbling block is the notion that alcoholism is simply a symptom of underlying psychologic problems and that correction of these will remove the need for the alcoholic to drink. No doubt there are underlying problems, but this thesis disregards abundant evidence to the effect that the problems cannot be efficiently attacked until the preoccupation with alcohol is controlled, and that the problems may be resolved in the process.

Regardless of how alcoholism begins or what sort of person the alcoholic was before, it is important to recognize that alcoholism produces, in a sense, a different person—a distortion of the original. The real person cannot be perceived by himself or by others until and unless he has been

released from the effects of the drug and from preoccupation with its use.

Read Mike's story again.

Recognition of alcoholism requires high levels of suspicion and empathy as well as awareness of the fact that it disrupts every aspect of the patient's life and usually of those close to him. The alcoholic and his family frequently don't recognize alcoholism as the cause of increasing problems in their lives, and they seek help reluctantly and late when they do. This is especially true of physician alcoholics and their families. Alcoholism is a stigmatized disease.

Mechanisms are available for identifying the physician alcoholic through impaired professional performance, but such impairment often is not evident until late in his course. Long before this, his family and close friends have known he was in trouble. Not being aware of the inevitable and relentless progression of his disease, fearing disgrace and financial disaster that might result from disclosure, and just simply hoping it will work out, they keep silent and their sickness progresses along with his.

Physicians sometimes treat patients without considering the fact that alcoholism may be causing or contributing to the hyperlipidemia, the obstructive pulmonary disease, the depression, the paranoia, for example. Furthermore, behavioral manifestations, often obnoxious and deceitful, are difficult to comprehend as symptoms of a potentially fatal disease; they may even cause us to reject the patient. We tend to overlook alcoholism even though its effects—physical, psychological, social, and spiritual—are quite evident. A syndrome is identifiable. "What causes problems is a problem."[3]

Mike's story is replete with clues.

Confrontation of the patient with the facts of his illness requires an attitude of firm kindness, sometimes called "tough love." Principles and procedures have been spelled out admirably by Maxwell[6] and Johnson,[7] and their books, although not available in most medical libraries, are highly recommended reading for anyone contemplating such an endeavor.

The object of confrontation is to overcome the arrogance and the powerful denial mechanism operating in the alcoholic by bringing him "messages from reality."[6] Then, he may become receptive to treatment. Here is where empathy, wisdom, patience, and faith are put to the test. We may fail and it may be necessary to repeat the confrontation again and again until that time when the unmanageability of his life is so painful that he will surrender and comply. Meanwhile, he and his family probably will suffer a great deal, and he may well die by suicide, by accident, or by the late effects of alcoholism before ever letting go of his compulsion. Alcoholism is a fatal disease, make no mistake about that.

When the physician alcoholic has progressed to the point where professional competence is impaired and this has been recognized by his peers, confrontation can proceed along lines similar to those used by industry, and he can be led or forced into treatment. He is faced with the reality of his unmanageability, is presented with firmly limited options, and is made responsible for his choice. This is not to say that he always accepts the evidence, even when it is overwhelming (that is part of his sickness), or that he always accepts treatment.

It is important that evidence presented at confrontation be as factual and explicit as possible. General references to "impaired preformance," "work not up to your (or our) usual standard," and other faults may be challenged in the manner of that old barroom cliche, "I can whip you with one hand behind my back!" Such is the nature and power of the denial mechanism so characteristic of this disease that some physician alcoholics threaten legal action against their "persecutors," not recognizing their own vulnerability to legal action by the State Medical Board. This is reminiscent of that other barroom challenge, "I dare you to step outside and say that." Some may reject confrontation and treatment by simply retiring, moving to another state, or going into a type of work where peer approval and medical licensure are not essential—and by continuing to drink. Such hazards and disappointments should not deter us. At least, we tried.

Of course, it would be far better if family and friends, who almost always know of the problem before professional competence is affected, could become sufficiently informed and so resolute that they would initiate confrontation earlier in the hope of saving the physician, themselves, and perhaps his patients from disaster. The Auxiliaries of our Academies of Medicine could be well advised to launch an educational program for this purpose.

Mike was not confronted.

Hope must be transmitted to the alcoholic beginning with the moment of confrontation and must be shared by those confronting and attending him. For a long time before he became aware, or was made aware, that he was out of control, the alcoholic was existing in a state of lonely, anxious, confused, and fearful isolation from which the only escape he knew was by way of the depressant drug, alcohol. Dimly aware of his chaotic life, he felt the pain of guilt, but the only way he could tolerate this was to exchange it for the paranoia of resentment by heaping blame on everyone and everything handy. To recognize the role of his drinking would mean he must abstain, and this he could not do. If he tried another way out, it was probably by suicide or by self-administration of some other depressant (easily and commonly done by physician alcoholics). If he asked for help, it was for relief of his agitated depression, and he spoke of past and current stresses and of the pressures of his work and his family life. He certainly did not tell the truth about his drinking, if indeed he was aware of the truth. And he drank again. He tried changing jobs, changing residence, even changing wives, but he could not see the necessity to change himself. And he continued to drink. And the chaos was compounded.

Now, it has been spelled out to him that he is a man out of control, and he is expected to stop drinking and to regain control. He is either angry, devastated, or, sometimes, grateful. He is uncertain and confused about what lies ahead, about what is meant by treatment, by recovery. Remember, he has been isolating himself in an oppressive sort of fantasy world. What is so clear to us about his chaotic life is not at all clear to him. If he has been thinking about his problems at all, it has been in terms of ridding himself of external pressures, not of changing himself. Now, he is faced with reality and the challenge to look at himself and to take responsibility for his reactions, his behavior. The notion that his abuse of alcohol and/or other drugs is an illness has probably not occurred to him before, and he may feel both frightened and relieved by it. Even the idea that others can and will help him may be perceived as a threat.

Little good will come of simply advising him to seek treatment. If he were capable of making good judgments and reliable decisions, it would not have been necessary to confront him. **We** must know that he can have a better life, **we** must know what proper treatment is, and **we** must know where it can be obtained. Then, **we** must take him there. Once there, willingly, or by coercion, he has a chance for recovery—hope. Alcoholism is a treatable disease.

But Mike died.

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Notice To Contributors

Members of the Kentucky Medical Association reading papers before other organizations are asked to submit their papers to *The Journal* for consideration by the Editors for publication. Detailed instructions to contributors appear in the Scientific Section of *The Journal* under Manuscript Memos. Please forward any papers to:

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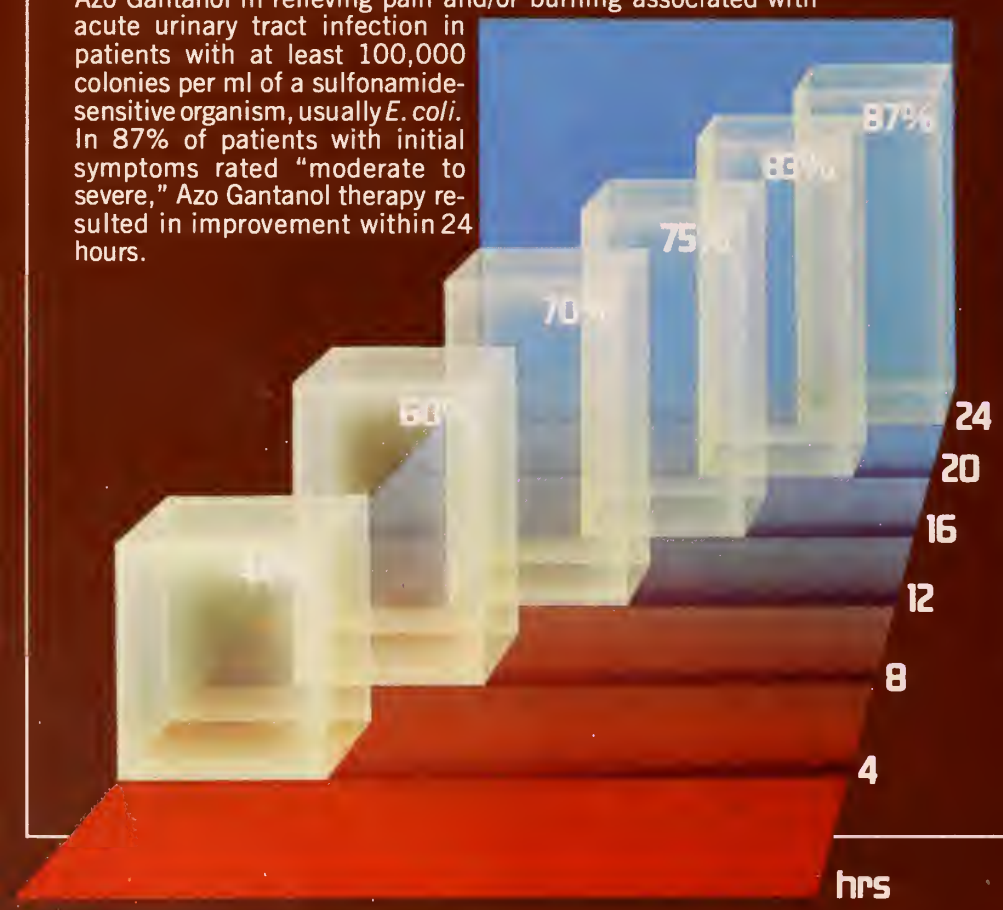

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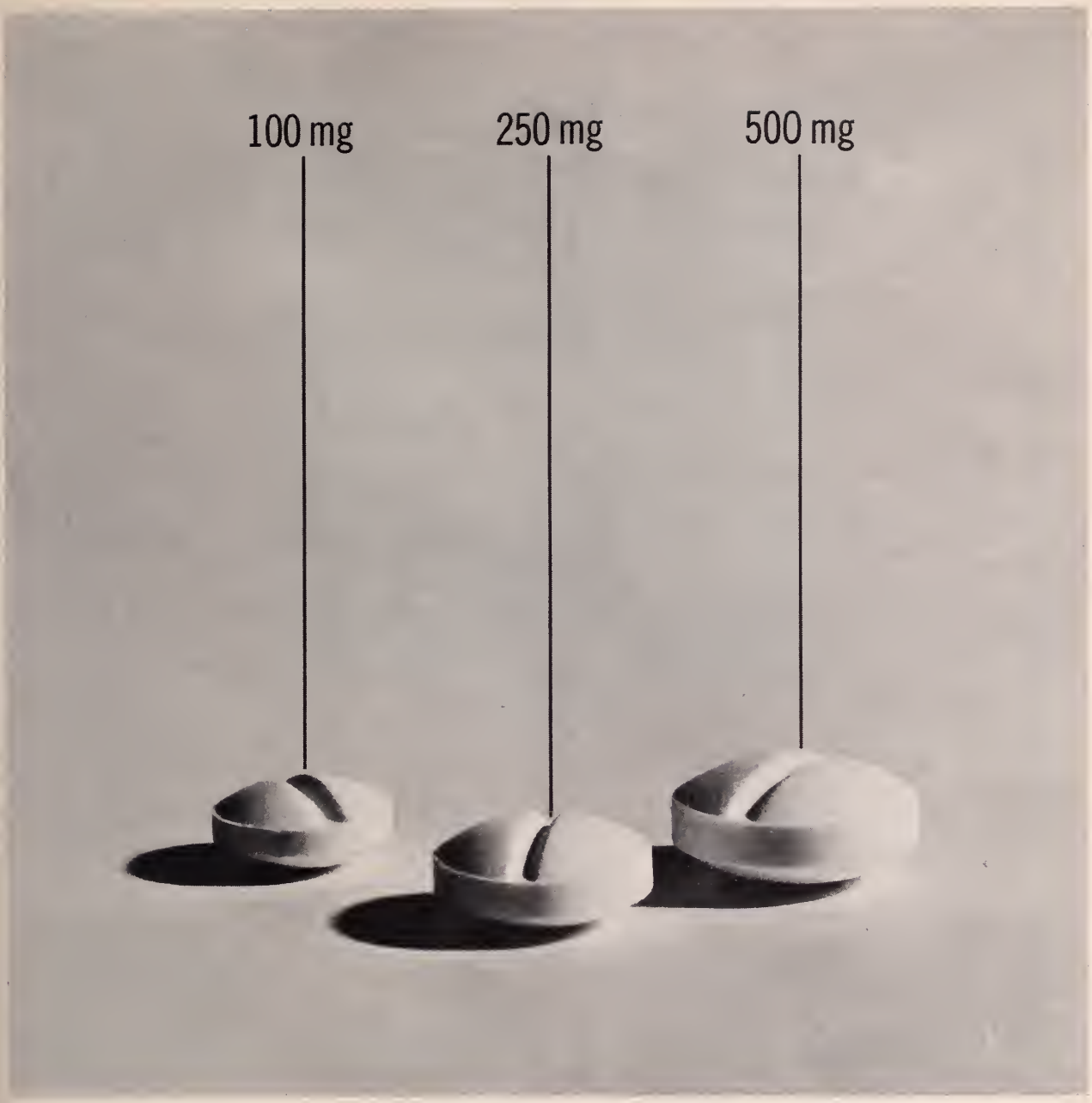

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ASSOCIATIONAL NEWS

Variety to Keynote 1978 KMA Annual Meeting Sept. 24-28 at Lexington Convention Center

"Varied and valuable" could best describe the program planned for the 1978 KMA Annual Meeting, to be held September 24-28 at the Hyatt Regency/Lexington Convention Center, Lexington.

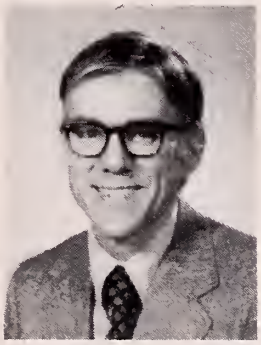
After a meeting of the House of Delegates on Monday, September 25, the General Session schedule will begin on Tuesday, September 26.

Themes for the General Sessions are "Pulmonary Disease" and "Endocrine." Nineteen specialty groups will hold afternoon meetings on September 26 and 28. Technical, scientific and health education exhibits will be displayed throughout the meeting. Physicians may obtain continuing medical education credit through the American Academy of Family Physicians and the American Medical Association (Physician's Recognition Award).

Other Annual Meeting events include the President's Luncheon on September 27, and a second House of Delegates meeting on September 27.

Among the featured speakers on Thursday morning, September 28, are Robert M. Fine, M.D., and Laurence S. Farer, M.D., both of Atlanta.

Doctor Farer



Doctor Fine

Doctor Fine is Clinical Associate Professor of Dermatology at Emory University School of Medicine, Atlanta. He will speak on "Rational Use of Steroids." Doctor Fine is a member of the American Academy of Allergists and the American College of Allergy, and has served as Editor of the *International Journal of Dermatology*.

Doctor Farer, whose topic is "The Role of Public Health in the Control of TB," is Director of the Tuberculosis Control Division, Atlanta. A graduate of the New York School of Medicine and Harvard University School of Public Health, Doctor Farer has served as World Health epidemiologist in India, consultant to the Pan American Health Organization in Venezuela, and advisor to the Peace Corps in Korea.

Complete details of the 1978 KMA Annual Meeting, including the final scientific program, will be featured in the August issue of *The Journal*.

1978 Scientific Program Outline Released for Annual Meeting

The following preliminary scientific program for the 1978 KMA Annual Meeting has been released. Each half-day session of the three-day program will feature a 30-minute intermission so physicians may visit the scientific and technical exhibits.

TUESDAY, SEPTEMBER 26—Morning Session

THEME: "Pulmonary Disease"

"Simplified Approach to the Assessment and Management of Acute Respiratory Failure"—Paul Stevens, M.D., Houston

"General Hospital and Office Treatment of TB"—John G. Weg, M.D., Ann Arbor

"Pros & Cons of IPPB"—James V. Maloney, M.D., Los Angeles

"Pre and Post Operative IPPB"—Terring W. Heironimus, III, M.D., Morgantown

"Pneumococcus Immunizations"—Sarah H. Sell M.D., Nashville

Nine of the 19 participating specialty groups will meet simultaneously at 1:30 p.m. No general session will be held at that time.

WEDNESDAY, SEPTEMBER 27—Morning Session

"Lipids: Current Profiles and Analysis"—Evan A. Stein, M.D., Cincinnati

"A Rational Approach to the Treatment of Cancer of the Prostate"—Joseph E. Davis, M.D., New York

"Craniofacial Birth Defects and Their Surgical Corrections"—Nicholas G. Georgiade, M.D., Durham

"Colonscopy"—Carl O. Knutson, M.D., Louisville

"Cancer Caused by Occupational Factors: A Perspective"—Bruce W. Karrh, M.D., Wilmington

"Role of the Physician in Obesity Treatment—Use of Rapid Weight Loss Supplemental Fasting Techniques"—George L. Blackburn, M.D., Boston

Afternoon Session
THEME: "Endocrine"

"Future Prospects for a Miniature Implantable Artificial Beta Cell"—J. Stuart Soeldner, M.D., Boston
"Thyroid Function Studies"—John W. Hollifield, M.D., Nashville
"The Importance of Cardiovascular and Renal Prostaglandins"—Michael J. Dunn, M.D., Cleveland
"Present Status of Estrogen Therapy"—Arthur L. Haskens, M.D., Baltimore

THURSDAY, SEPTEMBER 28—Morning Session

"Scar Camouflage Following Facial Injuries"—M. Eugene Tardy, Jr., M.D., Chicago
"Rational Use of Steroids"—Robert Fine, M.D., Atlanta
"Medical Aspects of Marijuana Use"—Donald W. Goodwin, M.D., Kansas City
"Treadmill Exercise"—Gerald F. Fletcher, M.D., Atlanta
"Clinical Use of Theophylin Including Blood Levels"—Phillip Lieberman, M.D., Memphis
"The Role of Public Health in the Control of TB"—Laurence S. Farer, M.D., Atlanta

The remaining ten specialty groups will meet at 1:30 p.m. There will be no general session in the afternoon.

President's Luncheon to Feature Governor Carroll

The Honorable Julian M. Carroll, Governor of the Commonwealth of Kentucky, will be the guest speaker at the traditional KMA President's Luncheon to be held at 11:50 a.m. in the Banquet Hall of the Lexington Convention Center, Lexington.

Governor Carroll

A native of McCracken County, Governor Carroll has been active in Kentucky politics since 1962, when he was elected to the Kentucky House of Representatives. During his fourth term in the Kentucky House, he was elected Speaker of the House and was reelected to that office in 1970. Governor Carroll served at Lt. Governor for three years.

An active lay minister, Governor Carroll in 1966 was named Moderator of the Kentucky Synod of the Cumberland Presbyterian Churches, the highest lay position of that organization. Governor Carroll also is a member of the Kentucky and American Bar Associations.

LOOKING AHEAD

September 24-28 KMA Annual Meeting, Hyatt Regency, Lexington

October 14 Regional Meeting, American College of Physicians, Lexington

Members in the news

HOYT D. GARDNER, M.D. IS VOTED PRESIDENT-ELECT OF AMA

Hoyt D. Gardner, M.D., was voted president-elect of the American Medical Association at its Annual Meeting, June 22, in St. Louis. Please see the story of Doctor Gardner's election following the Associational News.

Rose Gardner, Doctor Gardner's wife, was elected first vice president of the AMA Women's Auxiliary.

NEW MEMBERS

JEFFERSON
Taher Husainy, M.D., Louisville
Julia Mela, M.D., Louisville
Barry Schlossberg, M.D., Prospect
Alan G. Schuhmann, M.D., Louisville
Ronald E. Smith, M.D., Louisville
Gordon R. Tobin, II, M.D., Louisville
Peter T. Watson, M.D., Louisville

HONORS BESTOWED

The "Ad Astra Award" has been established at the University of Louisville School of Medicine. Presented to physicians for distinguished service, the award is a 10-inch miniature of the 22-foot high Ad Astra (Latin for "to the stars") sculpture of the Plaza at the University of Louisville Health Sciences Center. Recipients of the first Ad Astra Awards at the University of Louisville's May graduation convocation were **J. Murray Kinsman, M.D.**, former dean of the University of Louisville Medical School, and **Sherman M. Mellinkoff, M.D.**, dean of the UCLA School of Medicine.

* * * * * * * * * *

Randy Voyles, M.D. and **Jeff Welman, M.D.**, fourth-year surgery residents who have taken a year out of their training at Louisville General Hospital, Louisville, to study health care planning and health care cost problems, presented a program for medical students attending the American Medical Association Annual Convention in St. Louis, June 17-22.

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Donald R. Kmetz, M.D. Professor of Pediatrics and Associate Professor of Pathology in the University of Louisville School of Medicine, has been appointed Associate Dean for Children's Hospital in Louisville.

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Sam A. Overstreet, M.D., a member of The Journal's Editorial Board from 1955-72, was recently awarded the Jefferson County Medical Society's distinguished service award.

Scenes from 1978 Emergency Medical Care Seminar

Practical Program Highlights Emergency Care Seminar

More than 400 physicians, dentists, nurses, emergency medical technicians, paramedics, firefighters, administrators, and law enforcement officers attended the Eighth Annual KMA Emergency Care Seminar, June 7-9, at the Executive West Motel in Louisville.

Sponsored jointly by KMA and the Kentucky Department for Human Resources, the seminar featured a wide-ranging program that included two afternoons of practical instruction in cardiopulmonary resuscitation (CPR).

KMA's Emergency Care Seminar continues to draw a large registration despite the increasing number of like seminars around the state.

The top left photo shows a typical group attending a lecture session. Other photos are of instructors and students in the CPR course.

Trustees' Report

SIXTH TRUSTEE DISTRICT
Earl P. Oliver, M.D., Scottsville

The annual meeting of the Sixth Trustee District will be held at the Red Carpet Inn in Bowling Green on Tuesday evening, June 13, 1978. As of this date, approximately eighty-four members of the district and their guests are expected to attend the dinner meeting.

The program will consist of a brief business meeting, followed by remarks by KMA President, John Stewart, M.D., KMA Executive Vice President, Robert Cox, and KMA Auxiliary President, Mrs. Charles Nicholson. The principal speaker of the evening will be Douglas Freeman of Columbus, Ohio. Mr. Freeman is an executive of PICO.

Mr. Freeman will be on temporary duty in Louisville with our new Kentucky Medical Insurance Company, KMIC. His subject will be KMIC, the types of insurance offered to KMA members as well as expected premiums charged and the general way the company will do business. He will be available to answer questions at the end of his presentation.

All members of the Sixth Trustee District as well as all KMA members are urged to support our Insurance Company, KMIC.

FIFTEENTH TRUSTEE DISTRICT
Harold L. Bushey, M.D., Barbourville

Recently a group representing the KMA visited our senators and representatives in Washington. This time of sharing thoughts and renewing aquaintances yearly has been of mutual benefit. We are able to share our ideas and in return our elected officials were able to express their thoughts and concerns to us.

This trip might be compared to the visible portion of an iceberg. A lot is not visible. This is the home work done by our members communicating with and supporting our officials. This is a role that all our members can play. The time and effort contributed in getting to know and working with our officials is one way each member can contribute to our association.

Each of us needs to be involved. One obvious part is to work with our elected officials, national, state and local. KEMPAC's key man set up has been active in this area. Local Health Planning Committee, Peer Review Committee and HSA Committee all need medical expertise, and who better than the physicians can advise. Our KMA has need of committee members to help carry out the mandate. Again I urge each of you to get involved.

Headquarters Activity

JUNE

1	KMA Board of Trustees, Louisville
	KMA Insurance Agency Board of Directors, Louisville
3	Maternal Mortality Study Committee, Louisville
5-6	Washington Dinner, Washington, D.C.
7	McDowell House Board of Managers, Danville
7-9	Emergency Medical Care Seminar and Medical Services Conference, Louisville
8	Auxiliary Health Careers Day, Louisville
	First Trustee District Meeting, Paducah
12	*Journal* Editors, Louisville
13	Sixth Trustee District, Bowling Green
13-15	FLEX Exams, Louisville
14	Judicial Council, Louisville
	Fifteenth Trustee District, Barbourville
	Technical Advisory Committee on Physician Services (Title XIX), Louisville
15	Voluntary Cost Containment Joint Committee, Louisville
15-16	AAMSE 1978 National Educational Conference, St. Louis
17-22	AMA Annual Meeting, St. Louis
29	AD Hoc Committee on Hospital Based Physicians, Louisville

JULY

4	Office Closed
6	Membership and Placement Services Committee, Louisville
10	*Journal* Editors, Louisville
13	Board of Medical Licensure, Louisville

AUGUST

9-10	Board of Trustees, Louisville

Did you know . . .

More than 5,000 medical students and physicians-in-training borrowed more than $7.3 million last year through the American Medical Association Education and Research Foundation. Loans totaled $7,348,000 for an average of $1,422 each. Since the program began in 1962, the AMA-ERF has arranged and guaranteed loans amounting to approximately $85 million.

HOYT D. GARDNER, M.D.
1978 AMA PRESIDENT-ELECT

Rose and Hoyt Gardner, AMA Auxiliary First Vice President and AMA President-Elect.

Kentucky's Hoyt D. Gardner, M.D., was elected to the position of President-Elect of the American Medical Association during AMA's 1978 Annual Meeting in St. Louis, Missouri, on June 22. The election was the culmination of a low key, but sincere, campaign built on commitment and a proven record of service to organized medicine.

The 54-year-old Louisville surgeon has served as President of the Jefferson County Medical Society and KMA, as Chairman of the Board of both KEMPAC and AMPAC, has been a member of the AMA Speaker's Bureau for over 17 years, and was elected twice to the AMA Board of Trustees.

Doctor Gardner will become the eighth Kentucky physician to serve as President in the 132-year history of the AMA. Other AMA Presidents from Kentucky were Henry Miller, M.D., 1859-60; David Yandel, M.D., 1872-73; Joseph M. Mathews, M.D., 1879-1900; Lewis S. McMurty, M.D., 1905-06; Irvin Abell, M.D., 1938-39; Fred Rankin, M.D., 1942-43; and Elmer Henderson, M.D., 1950-51.

The Gardner Campaign theme was based on the "Call of Kentucky." Large full-color pictures of state park scenes, horses and harness equipment, and Kentucky Derby paraphernalia played a large role in promotional material and decorations.

In addition to President-Elect, elections were held for speaker of the house, four trusteeships, including the one vacated by Doctor Gardner, and several positions on the various standing AMA councils.

Mrs. Gardner also has been very active in medical affairs at the local, state and national levels. At the St. Louis meeting, Rose was installed as First Vice President of the AMA Auxiliary, during the Auxiliary's meeting, held in conjunction with the AMA meeting.

During the formal recognition of Doctor Gardner's election, the new President-Elect expressed his thanks to all the individual physicians who had supported his campaign and his goals, and dedicated his term of office to serving their needs.

He pledged during his tenure "to bring the Presidency and the AMA to the grass roots membership. We are an association of individuals, in federation to promote the best in American medicine," Doctor Gardner said. "I know you will help me to fulfill the goals of this office through expression of your individual opinions. I can only humbly commit myself to the fullest to translate those opinions into actions, and I am honored by the trust you have given me."

Doctor Gardner will serve in his new position for one year and will be inaugurated as President in June, 1979. He will succeed Tom E. Nesbitt, M.D., of Tennessee, who was installed as the 1978-79 President on June 21.

Scenes from the AMA Annual Meeting

A busy candidate.

Kentucky delegates caucus.

AMA House of Delegates.

A distinguished visitor, Dr. Karl A. Menninger (right). Dr. Bennett Crowder looks on.

Part of Kentucky's delegation: (left to right), Dr. Wally O. Montgomery, Dr. and Mrs. Harold D. Haller, and Dr. and Mrs. Kenneth Crawfor

J. Ed McConnell Awarded AMA Distinguished Service Citation

J. Ed McConnell (r), receives the AMA Citation of a Layman For Distinguished Service from then President-Elect Tom E. Nesbitt, M.D.

J. Ed McConnell, Louisville, was honored with the American Medical Association's "Citation of a Layman for Distinguished Service" in recognition of his dedication to the promotion of public health and better understanding of health care needs, and for a lifetime of service and devotion to the medical profession. The citation was made at the Annual Meeting of the AMA in St. Louis on June 18.

The Citation of a Layman for Distinguished Service is presented annually to an individual selected by the AMA House of Delegates at the Interim Meeting preceding the Annual Convention at which the plaque is formally awarded. The House makes its selection from not more than three nominees submitted by the Board of Trustees. The Citation is for individuals not of the medical profession who help achieve the ideals of medicine by cooperation or aid in the advancement of medical science, medical education or medical care. Mr. McConnell was nominated by the KMA Board of Trustees.

Mr. McConnell, recently retired president of Blue Cross and Blue Shield and Delta Dental of Kentucky, has supported the medical profession through his diligent actions in business, labor, and legislative arenas. He also has worked closely with the KMA, and in 1963, received its R. Haynes Barr Award.

Watch for the

August Journal

for

complete details

on the

1978 Annual Meeting

September 26-28

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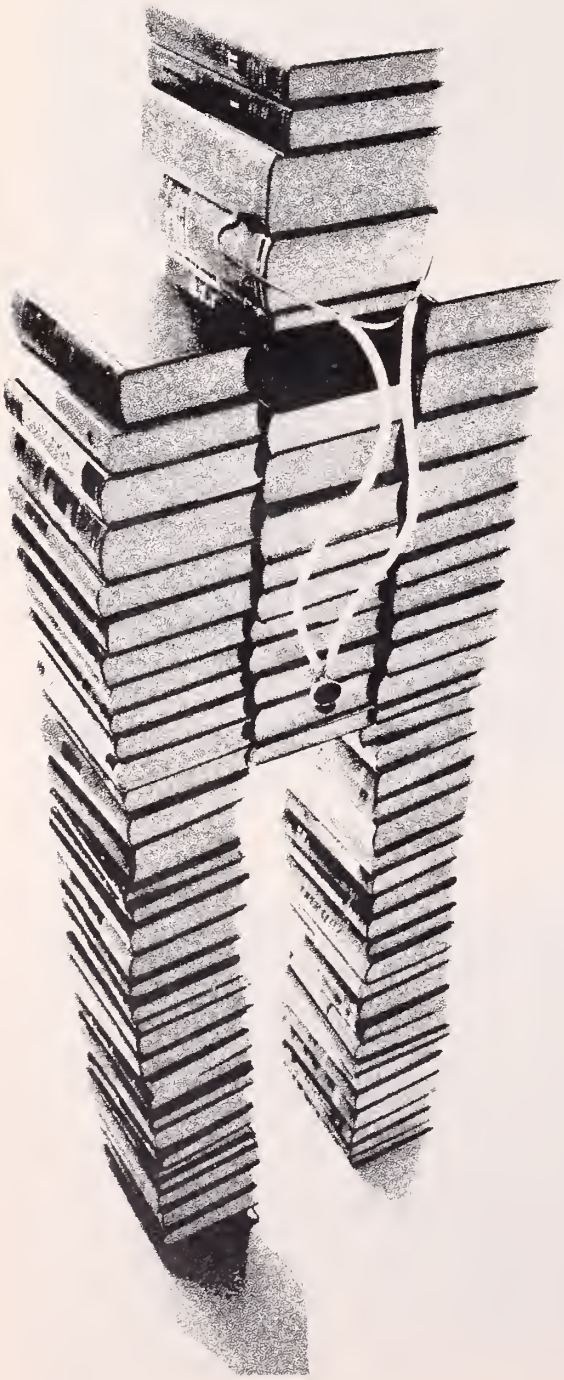

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You know what it takes to make a doctor. The motivation. The years of study and training. The dedication. The hard work.

But from the criticism leveled at doctors lately you'd think neither the public nor press had any idea.

It may surprise you, but the public does.

This was evidenced in a recent Harris Poll. In measuring public respect for U.S. leadership, it showed a drastic drop in the past five years. And "a majority of Americans is currently willing to express a 'great deal of confidence' in only one profession—medicine—on a list covering 16 types of activity." And that list included Congress and the Supreme Court.

People still look at their doctors as men to be respected and as men of integrity.

This is the true story of the American doctor. And one which the AMA is constantly telling the public as part of its communications program.

In newspapers and magazines, the AMA tells what it takes to be a doctor. American medicine's achievements. And to express the profession's concern by providing information to help every American lead a healthier life.

We can be an even more effective spokesman...with your support. Find out more about what the AMA does for you and the public. Send for a free pamphlet. Write: Dept. DW, at the address below.

JOIN US.
WE CAN DO MUCH MORE TOGETHER.

American Medical Association
535 North Dearborn Street/Chicago, Illinois 60610

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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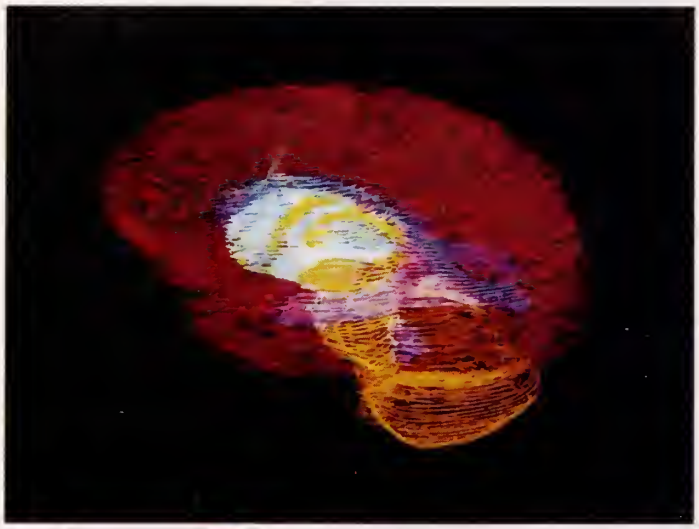

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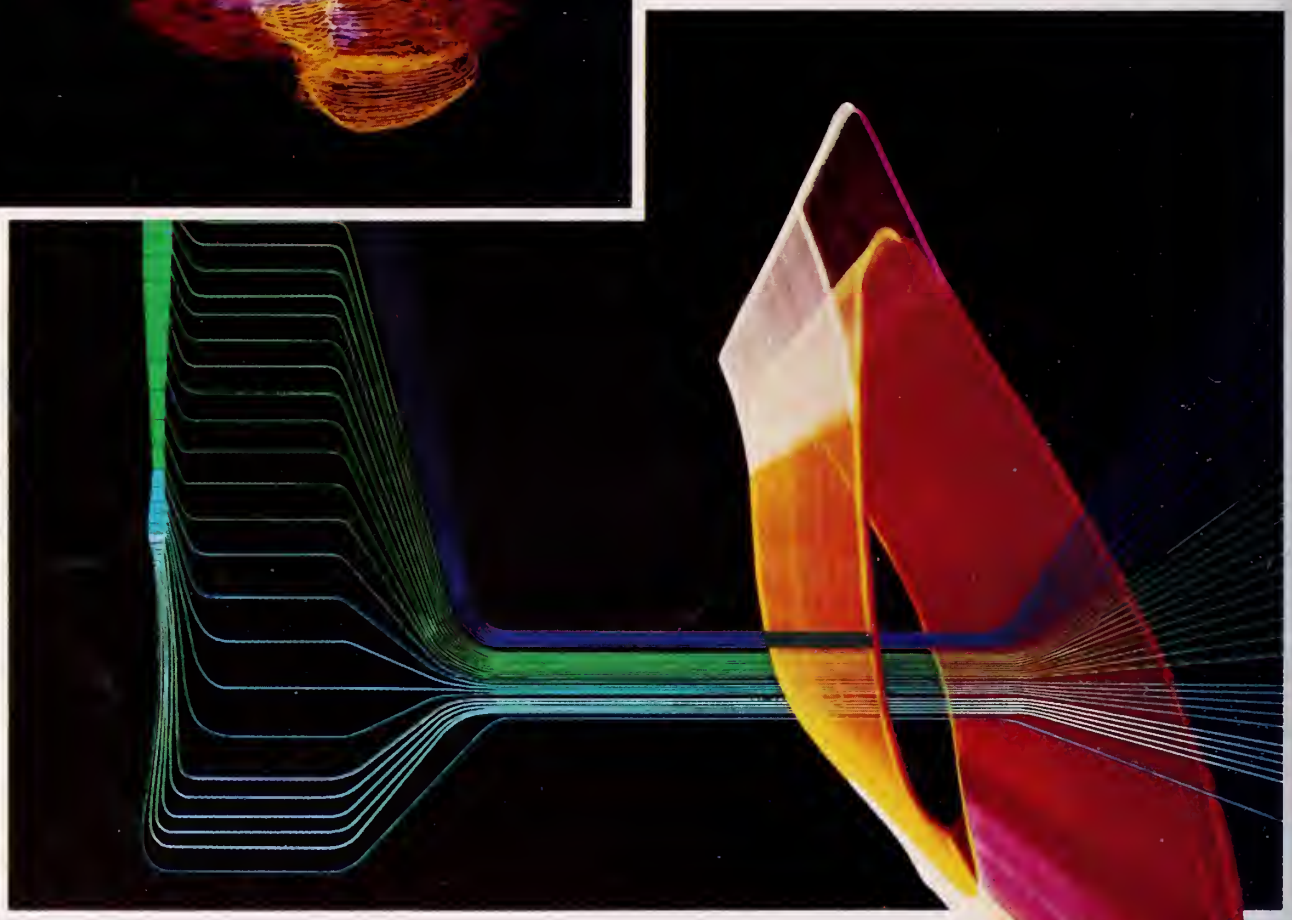

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the indi-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predispos-

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia,

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

AUGUST

14-18 3rd Annual Family Medicine Review**, Galt House, Louisville

23 "Common Athletic Injuries**," Louisville CME Consortium, Suburban Hospital, Louisville

SEPTEMBER

21-23 "Gynecologic Surgery," University of Louisville Department of Ob/Gyn, Louisville

24-28 KMA Annual Meeting, Hyatt Regency/Lexington Convention Center, Lexington

OCTOBER

4-6 "Topics in Medical Oncology" Symposium, Highlands Baptist Hospital. Contact Pat Strait, Coordinator, 810 Barrett Ave., Louisville, Ky. (502) 583-4841.

14 Kentucky Chapter, American College of Physicians Regional Meeting, Louisville

18 John Walker Moore Lecture, Health Sciences Center, Louisville

25-26 Hypertension—1978, Galt House, Louisville

NOVEMBER

9-10 Newborn Symposium**, University of Louisville School of Medicine

11-12 AMA Regional CME Meeting**, Louisville

13-17 Microsurgery for Gynecologists**, University of Louisville School of Medicine

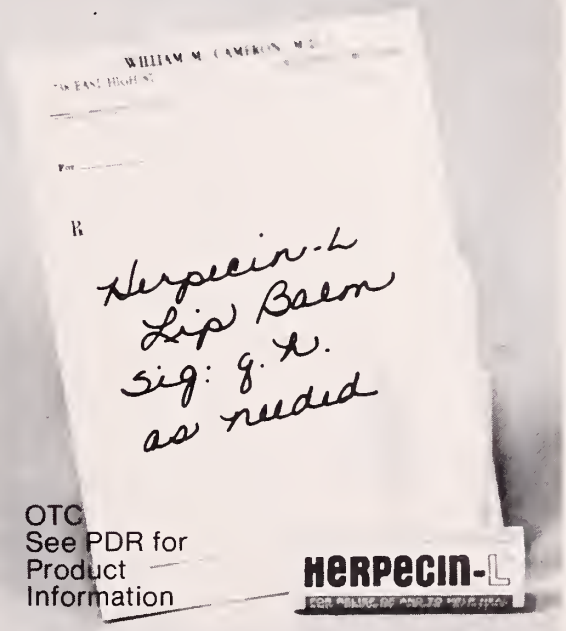
IN SURROUNDING STATES

SEPTEMBER

13-15 Cardiac Auscultation, University of Tennessee. Contact Mrs. Grace Wagner, UTCHS, 800 Madison Ave., Memphis, Tennessee 38163

29-30 Advanced Cardiac Life Support Course, Vanderbilt University, Nashville. Contact Carole Powell, American Heart Association, Suite 308, 1720 West End Building, Nashville, Tenn. 37203

Dx: recurrent herpes labialis



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MESSAGE FROM THE PRESIDENT

American Physicians vs. Socialism

AMERICAN physicians, like the socialists, believe in the care of the needy. We believe they should be housed, fed, and never medically neglected or denied, just as we believe in education, equal opportunity, sanitation, and preservation of a healthy environment. We have always and will continue to give our services to people in need, regardless of their ability to pay. We are annoyed by governmental inefficiency, program inequities and abuses—but support the basic concept of care of those in need.

Our differences with the socialists are primarily two: political and economic.

Politically, we believe in freedom and liberty; we believe them incompatible with socialism. Socialism calls for equality for everyone regardless of their abilities, productivity, or contributions to society. These aims call for more and more governmental regulations, and ultimately subjugation rather than development of the individual to the consensus. We oppose this philosophy. We believe in maximizing development of the individual. We believe the nation, and therefore the consensus, are stronger if the individuals are maximally (?) developed. We therefore believe in the necessary freedom and incentives to accomplish this goal.

Economically, the physicians believe in a sound system. We oppose the fiscal irresponsibility of government, the ever growing social programs leading to huge deficits paid with newly printed paper dollars in a course inevitably resulting in inflation, and the destruction of the purchasing power of the dollar. We oppose confiscatory taxation, worsened by inflation, that undermines the work ethic. We believe that labor, including physicians, should receive its just due, but pay increases should be tied to increases in productivity. If not, inflation results. We fear that national health insurance, free medicine for everyone, superimposed on all the current social programs, is unrealistic and would hasten our continued progress toward economic disaster. Economic soundness rests upon work productivity and creativity. Prosperity cannot last structured on debt and more paper dollars.

JOHN P. STEWART, M.D.
KMA President

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Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.
Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.
Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.
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Computer Assisted Tomography in Hemorrhagic Lesions of the Brain

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Several patients with a variety of hemorrhagic lesions of the brain have been presented. CT scanning provides a quick and safe method for early diagnosis of hemorrhagic lesions. It also is a guide for more intelligent applications of any further diagnostic studies which may be required. In many cases, CT scanning is the sole radiodiagnostic modality employed in evaluating patients with neurologic disease.

COMPUTER assisted tomography is the most sensitive modality in current use for adjunctive information and detection of hemorrhagic lesions of the brain. Because of its sensitivity to subtle difference in tissue contrast, the CT scanner shows areas of intracranial hemorrhage as dense white areas against the light gray of normal brain.[1]

With the advancement of the CT scanning it is now possible to determine configuration and size of intracranial hemorrhage, precise localization of single or multiple lesions, presence of blood in the subarachnoid space and extent of edema or infarction associated with hemorrhage.

CT gives the neuroradiologist an accurate picture of the hemorrhage in relationship to major anatomical structures, and shows distortion from adjacent edema, ventricular compression or obstruction, and herniation.

Materials and Methods

The EMI CT 1010 dedicated head scanner was utilized. Approximately 60 seconds of scan time is required to generate a pair of 8 mm. slices. The entire adult brain can be examined with six scan pairs and the total scan time is less than fifteen minutes.

Among the first 700 patients we studied with CT scans were 94 patients with hemorrhagic lesions (Table I Diagnostic Categories). The patients ranged from newborn to 81 years of age.

Renografin 60, an intravenous iodinated contrast medium, was employed for enhancement in characterizing hemorrhagic lesions. Enhancement is critical in identifying chronic or subacute subdural hematomas, aneurysms, arteriovenous malformations or tumor adjacent to hemorrhage, and areas of cerebral infarction.[2] In many cases cerebral angiography, with its attendant risks, was deferred.

Results

The abnormalities were divided according to their diagnostic categories (see Table I).

The category "other" included one patient with hemorrhagic diathesis from acute leukemia,

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Table I
Diagnostic Categories

Hemorrhagic Lesions:	Number of Cases
1. Acute Epidural Hematoma	2
2. Acute Subdural Hematoma	15
3. Isodense Subdural Hematoma	1
4. Chronic Subdural Hematoma	11
5. Arteriovenous Malformations	1
6. Aneurysms	14
7. Inflammatory Hemorrhagic Lesions	7
8. Traumatic Hemorrhagic Lesions	15
9. Basal Ganglia Hemorrhage	10
10. Brainstem Hemorrhage	6
11. Subarachnoid Hemorrhage Without Intracerebral/Extracerebral Hematoma	9
12. Other	3

a premature child with cerebral anoxia and venous periventricular hemorrhage, and a hemorrhagic metastatic deposit in an elderly patient with carcinoma of the bladder.

The first case was a comatose 35-year-old female suffering from acute myelocytic leukemia. CT scan revealed multiple hemorrhagic lesions. Post mortem examination revealed multiple hemorrhagic lesions with an increased right hemispheric mass effect and subfalcial herniation (Figure 1).

FIGURE 1. (1A & 1B) A non-infused scan reveals the suprasellar, pontine, and ambient cisterns completely filled with fresh subarachnoid hemorrhage.
(3A) A well circumscribed collection of high density material (white area) is seen medial to the atrium of the lateral ventricle. There is a smaller focal collection in the region of the anterior limb of the (R) internal capsule.
(5A) Two small high convexity focal hemorrhages, one in the (R) posterior frontal, the other parasagittally in the (L) parietal region. The interhemispheric fissure is filled with subarachnoid blood.
(Path Slide) Hemorrhagic areas appear black in the fixed specimen, but white on the CT scan.

The second case involved a three-day-old premature baby suffering anoxia during labor and delivery. After the third day of life, the infant developed seizures and arrested. An emergency CT scan revealed a periventricular right frontoparietal hemorrhage (Figure 2).

FIGURE 2. (2B) A non-infused scan shows dense (white) freshly clotted blood in the dilated occipital horns.
(4A) An intracerebral hemorrhage is seen in the (R) posterior frontal parietal lobe communicating with the body of the (R) lateral ventricle. Some blood is seen in the interhemispheric fissure.

The third case involved a 65-year-old cachetic, confused male with previously diagnosed Stage II transitional cell carcinoma of the bladder. CT scan revealed an area of high density in the right periventricular parietal region (Figure 3).

FIGURE 3. (4A) A non-infused scan shows an area of high density in the (R) parietal region and a slight impression on the atrium of the (R) lateral ventricle. A minimal area of lucency is seen around the area of high value. This most likely represents resolving hematoma or edema surrounding a metastatic tumor. There is evidence of midline shift.

Hemorrhage within or adjacent to a cerebral metastasis is not uncommon.[3] Primary brain neoplasms are much less prone to develop hemorrhage. It is important to consider metastatic disease as a possible cause of intracerebral hemorrhage in the presence of (a) an atypical clinical setting or bleeding site, (b) contrast enhancement early in the clinical course, or (c) multiple lesions.[4]

Spontaneous Hypertensive Intracerebral Hemorrhage

Spontaneous intracerebral hemorrhage in the middle age or elderly hypertensive patient typically involves the basal ganglia, especially the putamen, and the thalamus. Hemorrhages into the cerebellar hemispheres and brainstem are also seen. Clinically, the patients are frequently deeply comatose and may not exhibit accurate lateralizing signs. Diagnostic studies are undertaken in these patients with the hope of identifying a surgically remediable cause of coma; that is, an expanding mass (hematoma) which can be evacuated without increasing the patients' neurological deficit.

Most spontaneous hypertensive bleeds are deep and are not accessible surgically. The CT scan provides a quick and precise localization of hemorrhage without subjecting this high risk group of patients to cerebral angiography. Such accurate localization effectively determines whether the management of the patient will be along surgical or medical lines.

This case involved a 68-year-old unresponsive, hypertensive male brought to the Emergency Room. Neurological manifestations included upgoing Babinski reflexes, fixed pupils and rigid extremities. CT scan revealed a massive left basal ganglia hemorrhage with evidence of rupture into the ventricular system (Figure 4).

FIGURE 4. (1A) A non-infused scan shows a dense hemorrhage involving the anterior perforated substance

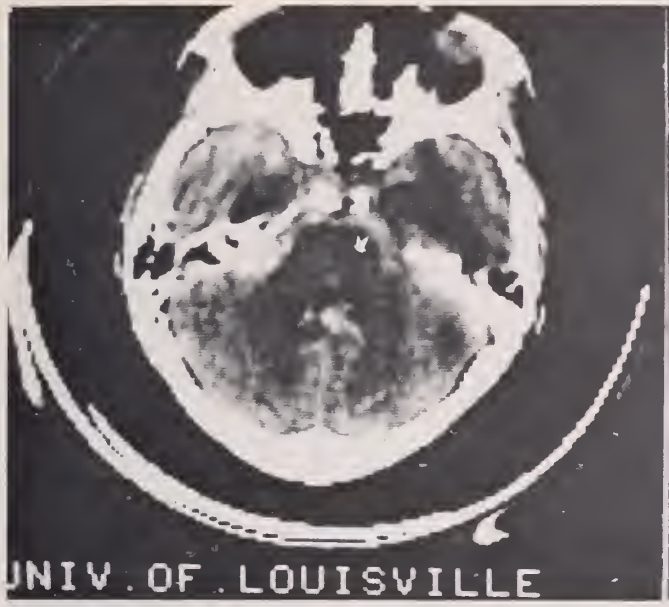

Fig. 1, 1A

Fig. 1, 1B

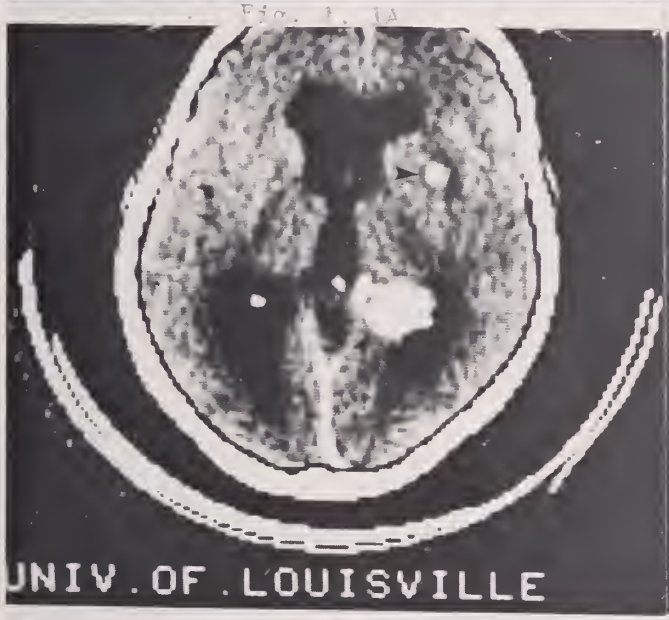

Fig. 1, 3A

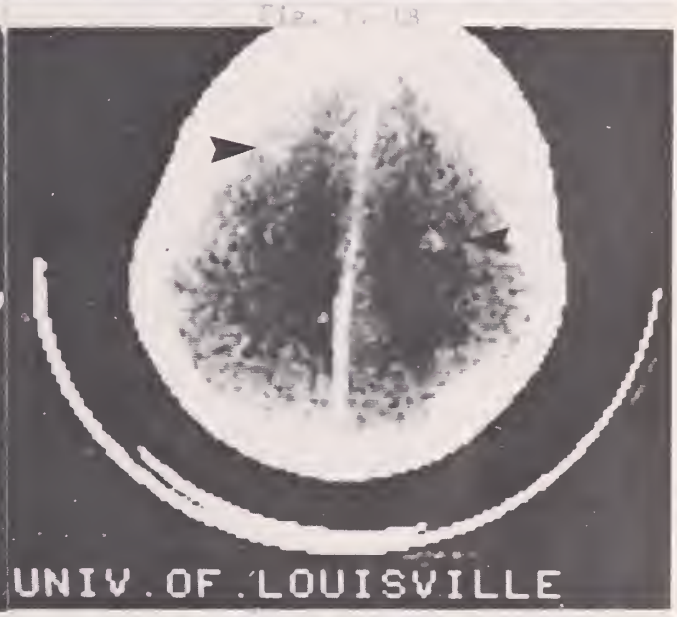

Fig.1, 5A

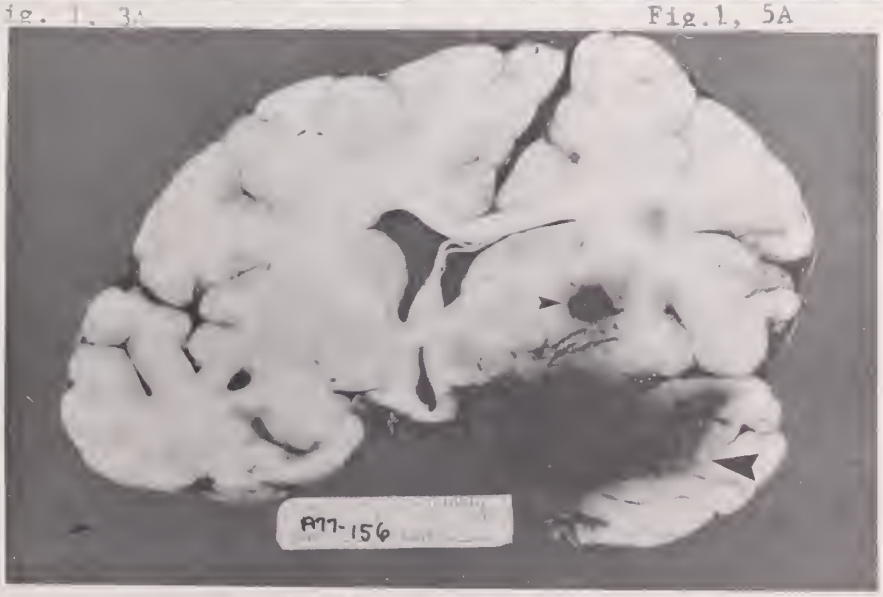

Fig. 1, Pato Slide

Fig. 2. 2B

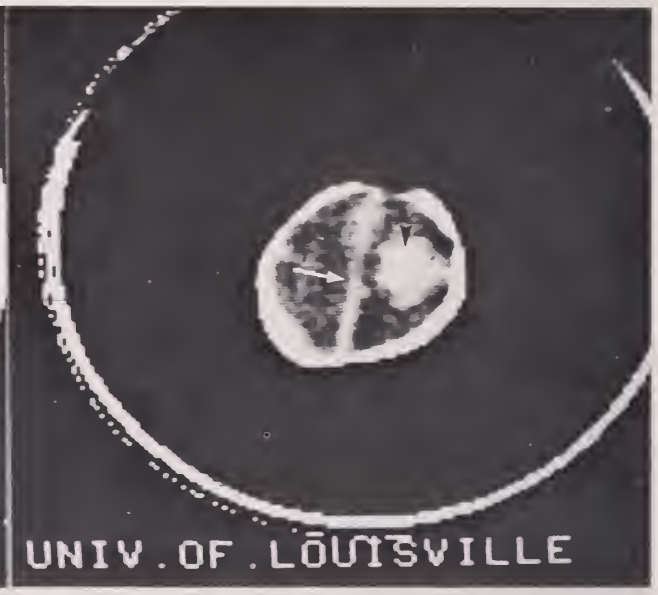

Fig. 2. 4A

Fig. 3. 4A

Fig. 4. 1A

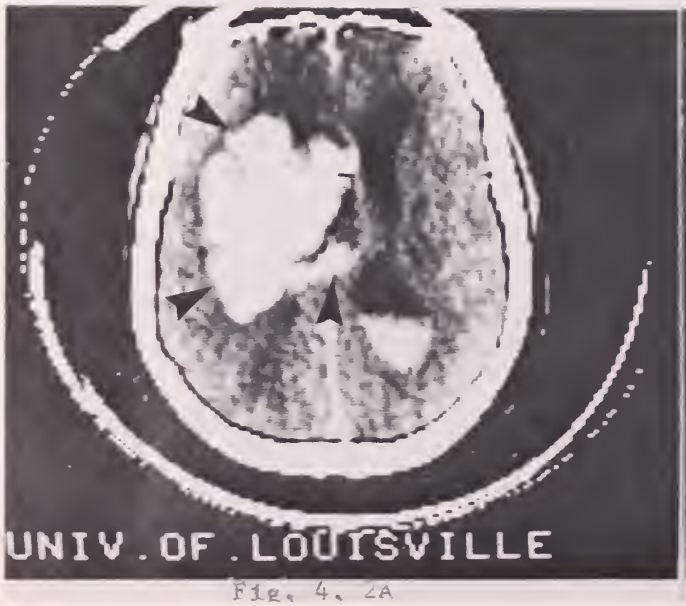

Fig. 4. 2A

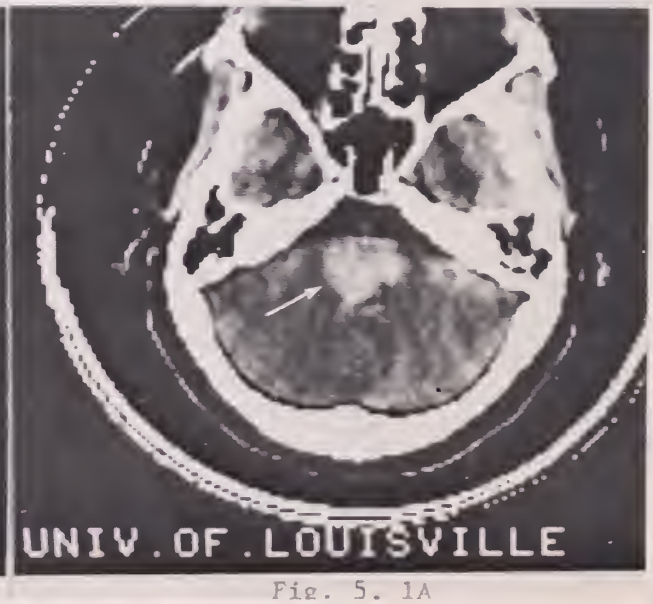

Fig. 5. 1A

and lower basal ganglia. The mass of the hematoma compresses the anterior (L) temporal horns. A blood/CSF level is seen in both occipital horns.
(2A) The hematoma extends superiorly to involve the entire (L) basal ganglia and anterior thalamus. Rupture into the (L) lateral ventricle is seen medially.

Brainstem Hemorrhage

Spontaneous hemorrhage within the posterior fossa produces a dramatic, life threatening clinical picture of brainstem compression. Cerebral angiography in these patients is frequently not helpful in precise localization of the hematoma. CT offers quick distinction between surgically amenable lateral cerebellar hemispheric hemorrhages and inaccessible brainstem hemorrhage.

This case involved a 36-year-old unresponsive, hypertensive male brought to the Emergency Room after complaining of posterior headaches and increasing shortness of breath. Progressive rapid neurological deterioration followed. An emergency CT scan revealed primary pontine hemorrhage (Figure 5).

FIGURE 5. (1A) A non-infused scan shows a large area of high density in the low posterior fossa at the level of the mid pons. There is some extension of the hemorrhage laterally into the (R) cerebellopontine angle cistern. The fourth ventricle is obliterated.
(1B) The upper level of hemorrhage appears to be roughly in the low mesencephalon.

Acute Epidural Hematoma

Acute epidural hematomas are seen as a biconvex or lenticular shaped high density collection.[5] The collection is homogeneously dense and exerts considerable mass effect. The interface between brain and epidural hematoma is sharp, and the hematoma abuts directly on the inner table of the skull. Skull fractures are usually seen on plain skull films in these patients; however, fractures are not often seen on CT scans.

The first case involved a 43-year-old unresponsive male brought to the Emergency Room after falling 30 feet. Clinical manifestations were fixed and dilated pupils, rigid extremities, and upgoing Babinski signs. CT scan revealed a huge right epidural hematoma with intraventricular and subarachnoid hemorrhage (Figure 6).

FIGURE 6. (2A) A non-infused scan showed that the mass is convex medially and has the density of freshly clotted blood. There is uncal herniation and medial displacement of the middle cerebral artery and the internal carotid artery.
(3A) There is tremendous midline displacement with complete collapse of the (R) lateral ventricle and hemorrhage within the (L) occipital horn.
(4B) High density within the interhemispheric fissure and sylvian fissure indicates blood in the subarachnoid space. The lentiform collection extends from just beneath the (R) temporal lobe over the parietal convexity.

The second case involved a 16-year-old responsive male brought to the Emergency Room with a gunshot wound to the occiput near the confluence of sinuses. Progressive neurological deterioration followed. An emergency CT scan revealed a posterior fossa acute epidural hematoma. The bleeding source in this case was the large torcular venous complex. Posterior fossa epidural collections are usually venous, occupy less volume and are under less pressure than supratentorial arterial epidural hematomas (Figure 7).

FIGURE 7. (2A & B) There is a band of high density material over the surface of the (L) cerebellar hemisphere posteriorly. The fourth ventricle is compressed and displaced to the right. There is moderate dilatation of the third and lateral ventricles.

Subdural Hematoma

Acute subdural hematoma presents as a dense extracerebral collection concave medially in contrast to the convex medial border of the acute epidural. The interface with underlying brain may be less distinct than with acute epidurals, as there is invariably cortical laceration and contusion associated with subdurals. As the blood is resorbed and breaks down, the density of the collection decreases, reaching isodensity with brain tissue at roughly two to three weeks.[6] Ultimately, the density approaches that of cerebrospinal fluid as the collection reaches the chronic stage. As the chronic subdural develops a membranous encasement and expands, its configuration changes from concave medial to convex medial.

An acute subdural hematoma was clearly demonstrated in the case of a 62-year-old male brought to the Emergency Room with recent head injury. The pupils were equal but non-reactive; the right extremities responded only to pain. A CT scan revealed an acute right convexity subdural hematoma with frontal lobe contusion and hemorrhage (Figure 8).

FIGURE 8. (2B, 4A) There is a large high density extracerebral collection over the entire (R) hemisphere. There is compression of the (R) lateral ventricle and

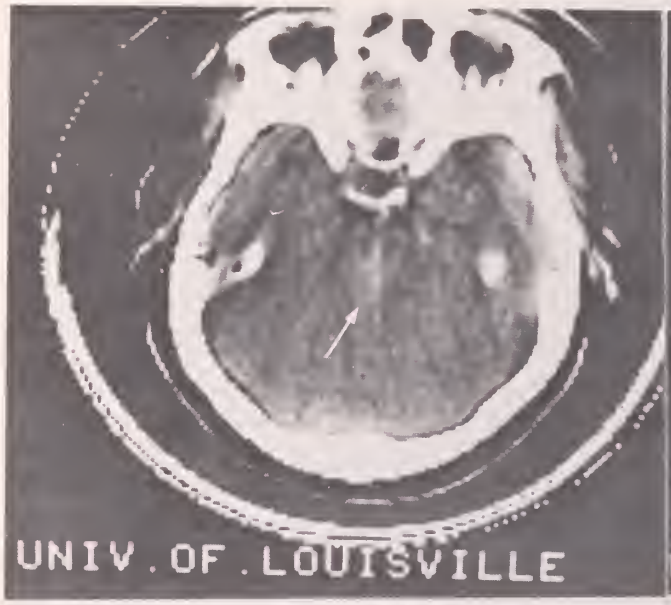

Fig. 5, 1B

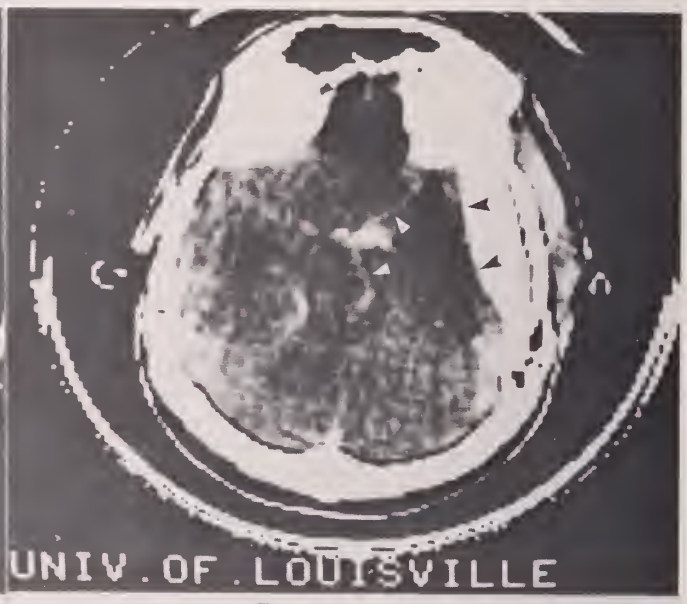

Fig. 6, 2 A

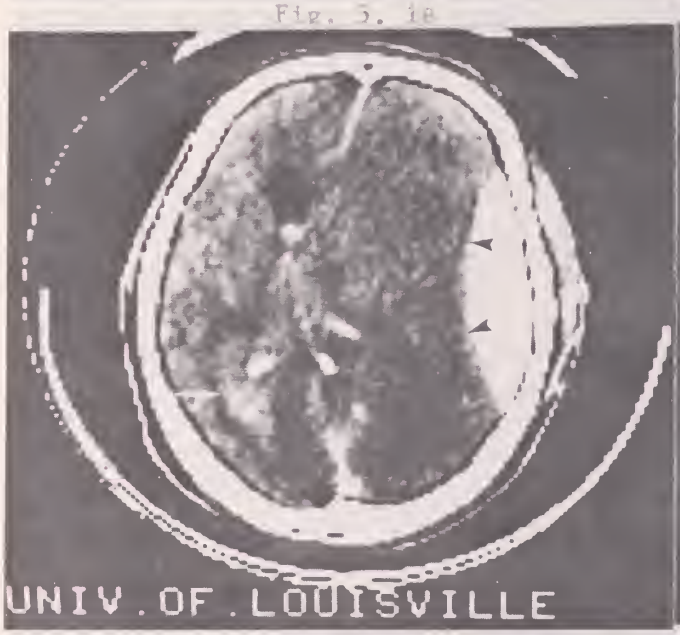

Fig. 6, 3B

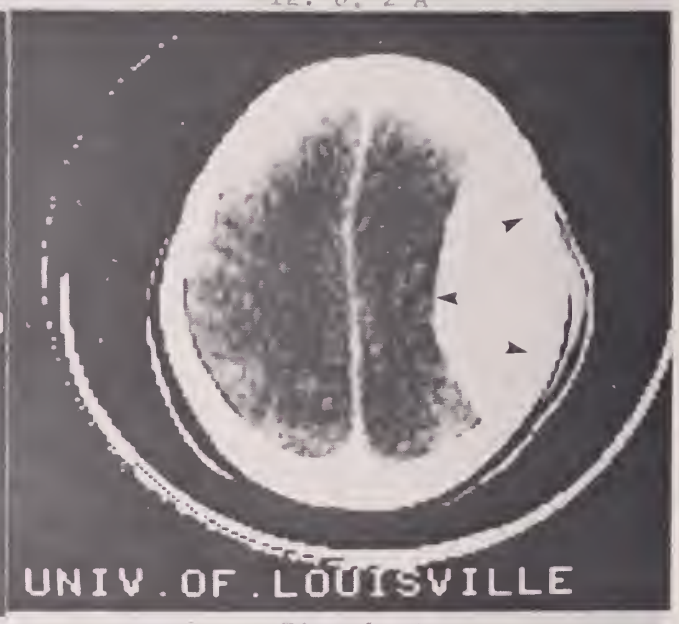

Fig. 6, 4B

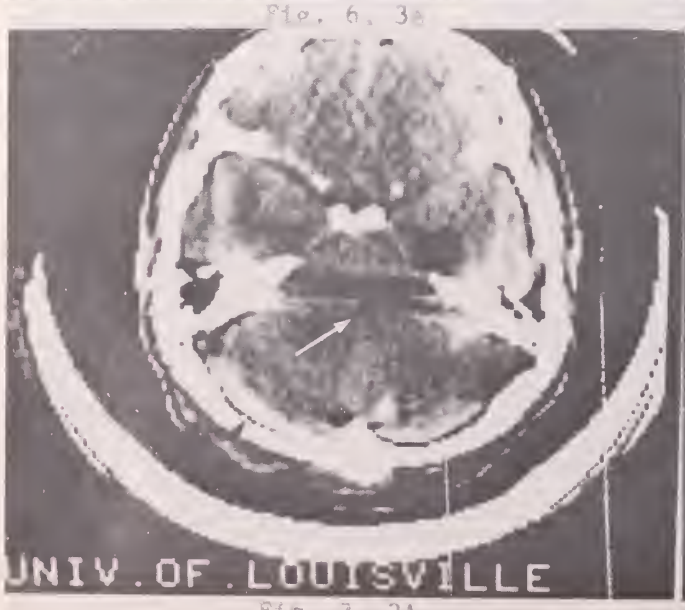

Fig. 7, 2A

Fig. 7, 2 B

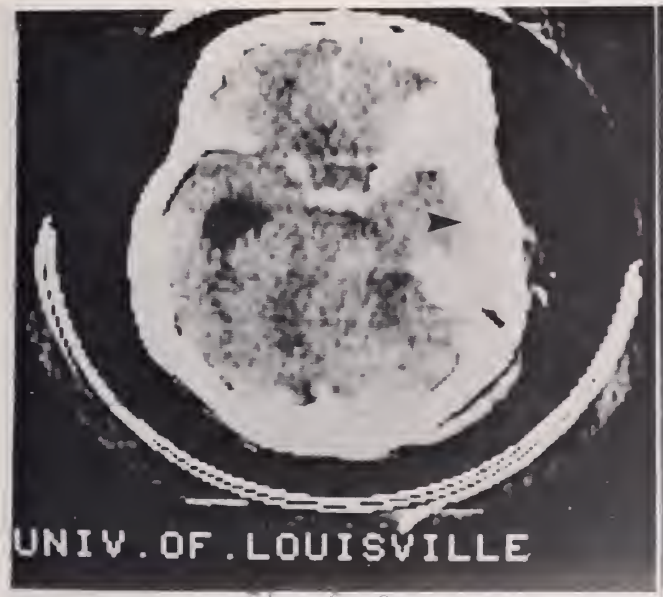

Fig. 8, 2B

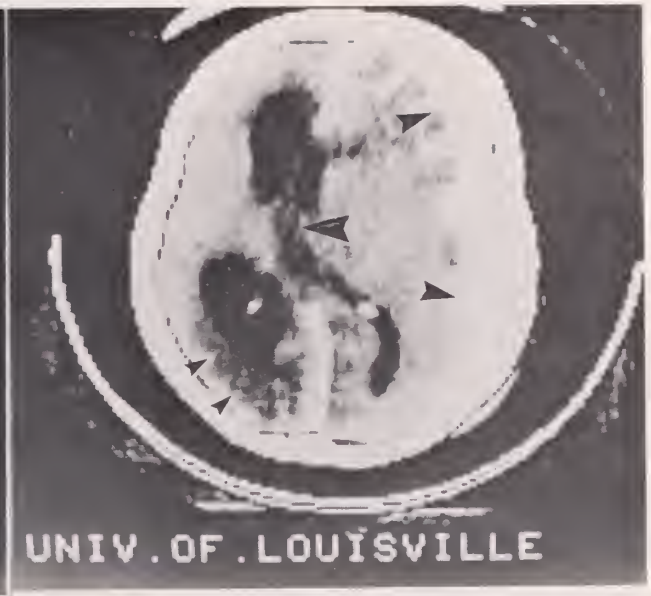

Fig. 8, 4A

Fig. 8, 5B

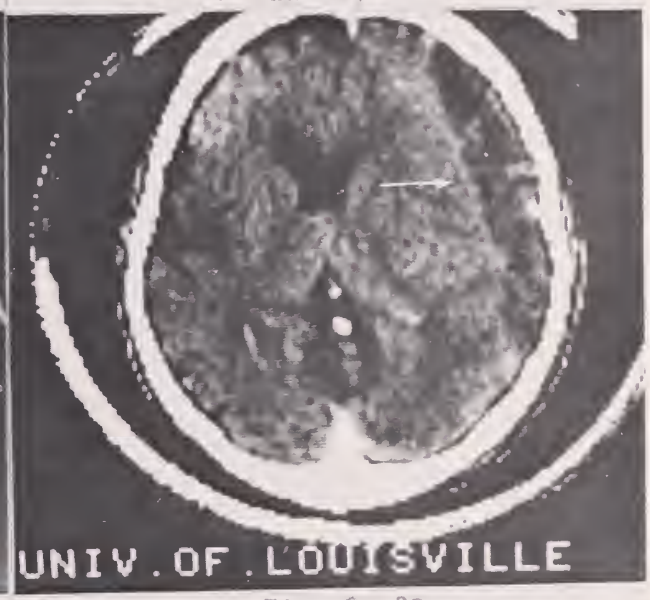

Fig. 9, 3B

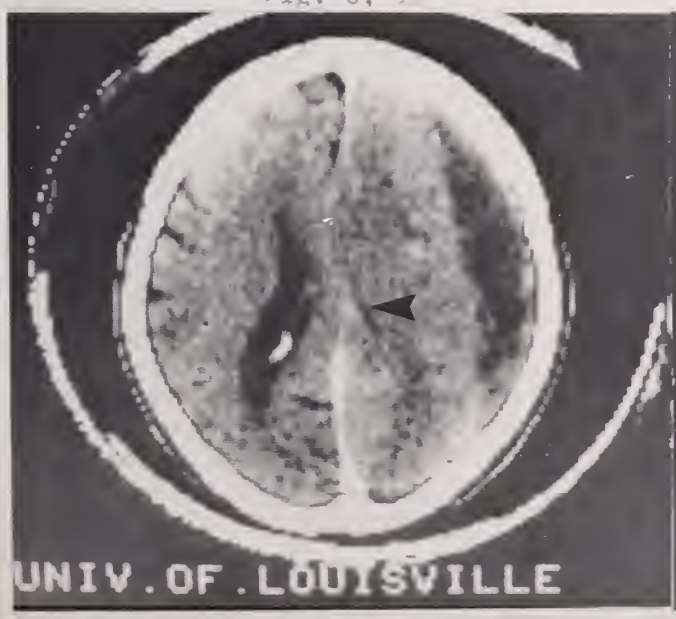

Fig. 9, 5B

Fig. 9, 7A

massive (R) to (L) shift. The periventricular lucency surround the (L) lateral ventricle suggest ischemia in the (L) posterior cerebral artery. This probably developed as a result of downward transtentorial herniation.
(5B) The hematoma extends over the high convexity. The (R) parasagittal lucency is probably due to ischemia in the anterior cerebral territory from subfalcial herniation.

Chronic subdural hematoma is seen on the CT scan as a low density extracerebral collection. The absorption value, or density will vary depending upon the age and extent of the lesion.

Secondary features of chronic subdural hematoma include: dislocation of the midline structures, compression of the ventricles, and displacement of the cortical surface away from the inner table of the skull.[7]

This case involves a 75-year-old confused male admitted to the hospital complaining of the right upper quadrant pain. A subdural hematoma was suspected from plain skull examination showing pineal shift. CT scan revealed a chronic subdural in the right convexity measuring 3.5 cm. in size (Figure 9).

FIGURE 9. (3B) Post infusion scan shows a lucent extracerebral collection over the (R) convexity in the frontoparietal region with flat medial border and faint membrane enhancement medially.
(5B) The (R) lateral ventricle is almost completely compressed. A significant shift of the midline to the (L) is obvious.
(7A) The extracerebral collection extends from the low frontal convexity to the high parietal convexity. Note absence of sulci pattern on the right convexity, compared to atrophic widened sulci on the left.

Rebleeding into an existing chronic subdural hamatoma may develop as stretched veins bridging cerebral cortex and dural sinuses are torn by often insignificant trauma. Disruption of the friable, vascular subdural membrane by minor trauma is also seen.

A 61-year-old confused and disoriented male complained of headache after falling out of bed four weeks prior to admission to the hospital. The initial CT scan was performed showing moderate cortical atrophy and bilateral chronic subdural collections over both frontoparietal regions. After several more falls, the patient deteriorated neurologically and another CT scan was performed. Rebleeding into the left subdural was now causing considerable mass effect (Figure 10).

FIGURE 10. (12B) Initial CT scan on admission shows the ventricular size is increased and there is no midline shift. Thin lucent extracerebral collections are seen over both frontal tips. The CT picture is one of diffuse atrophy with thin bilateral chronic subdural hematomas or hygromas.
(3A) A non-infused scan after neurological deterioration revealed that the (L) lateral ventricle is compressed and there is tremendous displacement of the midline structures. Over the entire left convexity, there is an extracerebral collection with a fluid/blood interface seen indicating rebleeding into the previously documented chronic subdural.

The isodense, or subacute, subdural hematoma may be very difficult to identify due to its smooth interface with underlying brain and similar attenuation values of brain and the extracerebral fluid collection. This case involved an 81-year-old confused but responsive male with history of falling and hitting his head approximately two weeks before being admitted to the hospital. No focal neurological deficits were seen upon physical examination. CT scan revealed an isodense subdural collection over the right hemisphere (Figure 11).

FIGURE 11. (4B) A non-infused scan shows only a suggestion of an isodense collection over the (R) convexity.
(5A) The sulci on the (R) are not as prominent as those on the (L), and do not reach the inner table of the skull.
(24B) Initially after contrast injection, there was no enhancement. Views taken one hour after injection demonstrate a band of moderate homogeneous enhancement throughout the extracerebral collection, and covering the mid and high (R) frontoparietal convexity. This case demonstrates the necessity of contrast infusion in patients with recent head trauma and equivocal CT findings.

Spontaneous Subarachnoid Hemorrhage

The most common causes of spontaneous subarachnoid hemorrhage are aneurysms and arteriovenous malformation. Cerebral angiography is necessary in these patients to outline the lesion which has ruptured, and to determine the presence of associated mass, vascular spasm and associated communicating hydrocephalus.

In many cases the diagnosis of subarachnoid hemorrhage can be made by CT scan alone. Subarachnoid blood can be seen as high density material filling the basal cisterns, sylvian fissures and interhemispheric fissure. Ischemic areas, intracerebral or extracerebral hematomas and hydrocephalus can also be seen.

Lumbar puncture should be withheld in these patients until a CT scan, if available, is performed to check for expanding hematoma or

Fig. 10, 3A

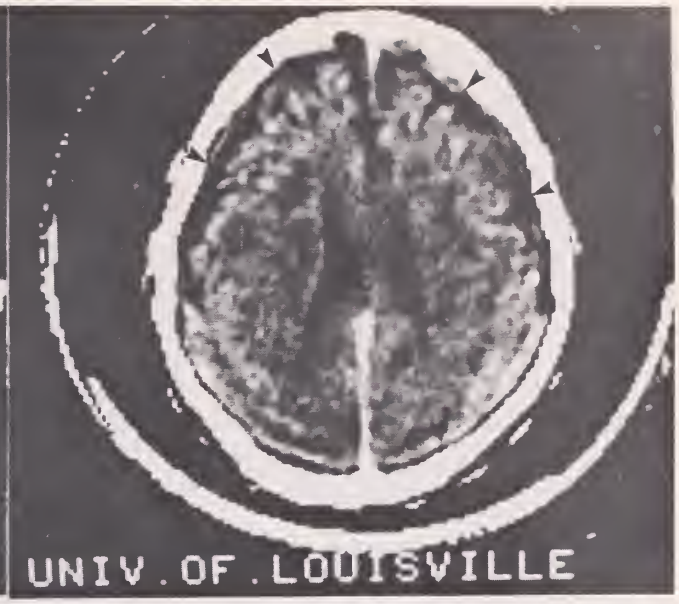

Fig. 10, 12B

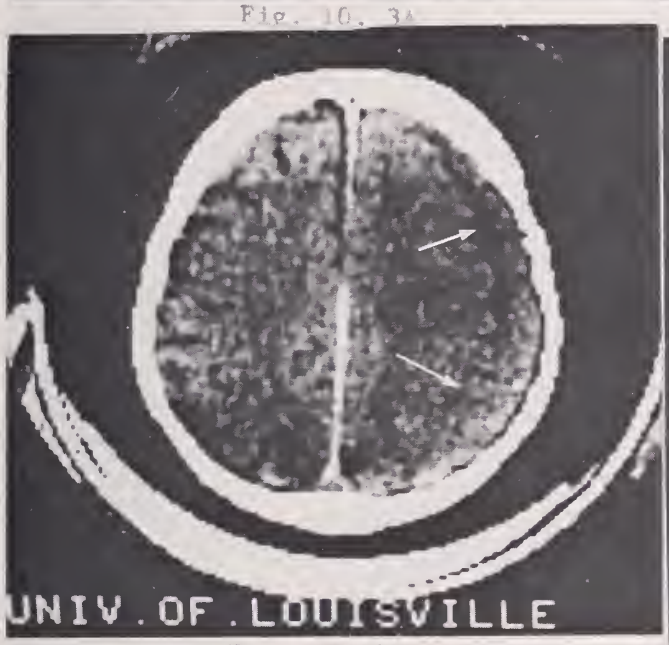

Fig. 11, 4B

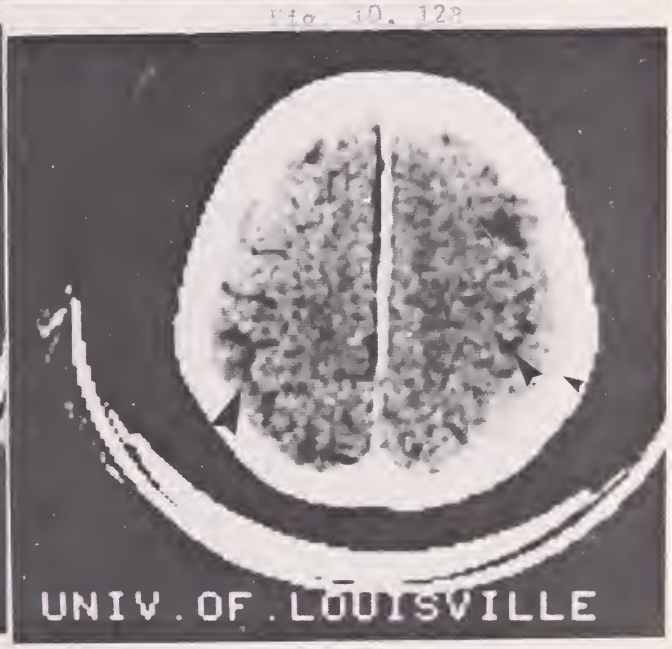

Fig. 11, 5A

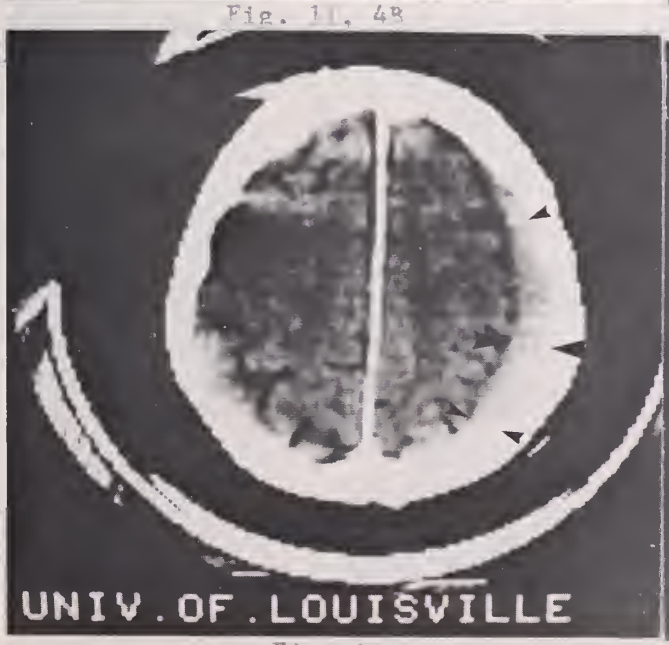

Fig. 11, 24B

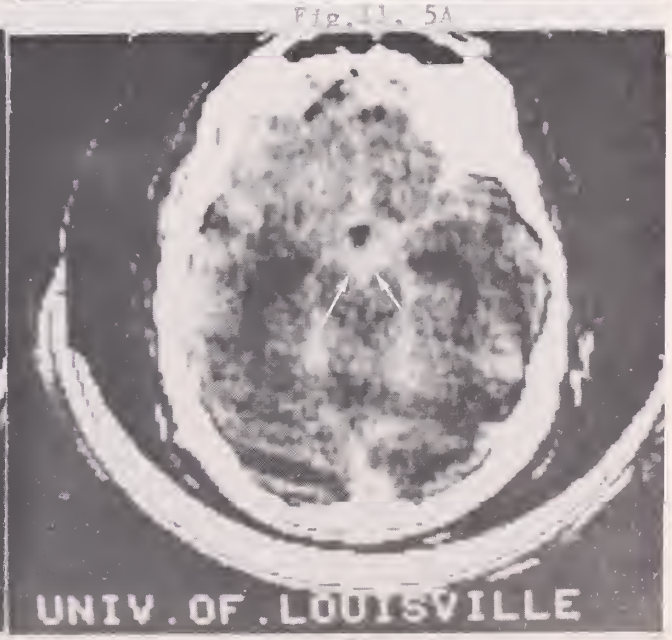

Fig. 12, 12B

Fig. 13, 2A

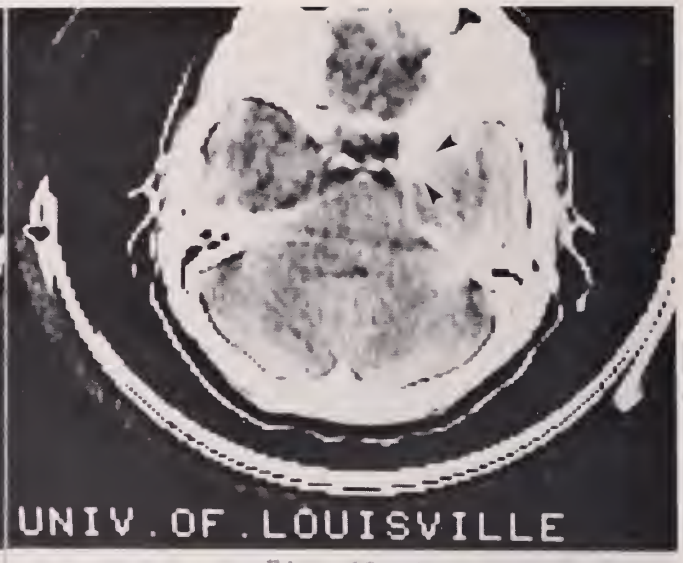

Fig. 13, 11A

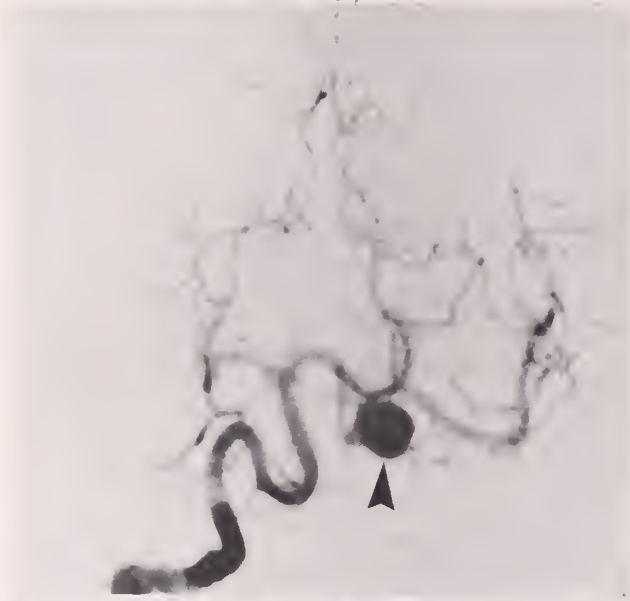

Fig.13, Angiogram

Fig. 14, 2B

Fig. 14, 12 A

Fig. 14, 12B

other mass. The CT scan is extremely helpful in the management of patients with subarachnoid hemorrhage, but the quantitative value of the spinal tape and precise anatomy of cerebral angiography are still essential.

A 43-year-old hypertensive male was brought to the Emergency Room complaining of severe headaches, increasing confusion, neck rigidity and a right homonymous heminopsia. A lumbar puncture revealed blood in the spinal fluid. A CT scan revealed a subarachnoid hemorrhage (Figure 12).

FIGURE 12. (12B) The high density material outlines the suprasellar cistern. There is no evidence of intracerebral or extracerebral hematoma. There were no abnormal areas of enhancement to localize the source of subarachnoid bleeding.

Aneurysms

Identification of the source of primary subarachnoid hemorrhage involves correlation of cerebral angiography and CT scanning. The angiogram outlines the structural feature of the causative aneurysms or malformation. CT scanning offers complementary information: the true size of a partially thrombosed aneurysmal sac, associated intracerebral or extracerebral hematoma, infarction due to accompanying vasospasm and development of hydrocephalus. In addition, in the case of multiple aneurysms, the CT scan may be a more accurate predictor of the site of bleeding than traditional angiographic criteria.

The first case involved a 56-year-old female complaining of vertigo. Five years ago, she underwent ligation of the right common carotid for an internal carotid aneurysm. CT scan strongly suggested an aneurysm in the right parasellar area (Figure 13).

FIGURE 13. (2A) A non-infused scan shows a prominent suprasellar cistern.
(11A) A post-infusion scan reveals a discrete round area of homogeneous enhancement just to the right of the suprasellar cistern which undoubtedly represents the posterior communicating artery aneurysm seen on the angiogram.

The second case involved a 43-year-old female brought to the Emergency Room complaining of severe headache and vomiting. Neurological manifestations included papilledema. CT scan revealed a subarachnoid hemorrhage with focal hemorrhage into the low frontal lobes, septum pellucidum, and corpus callosum with probable demonstration of an anterior cerebral artery aneurysm. There was mild to moderate hydrocephalus (Figure 14).

FIGURE 14. (2B) A non-infused scan shows the third and lateral ventricles are moderately dilated. There is a large dense collection, representing hemorrhage, between the two frontal horns and beneath them, low in the interhemispheric fissure. Blood also outlines the sylvian fissures.
(12A) Post infusion scan shows the (L) supraclinoid internal carotid artery larger than the (R). This dilatation proved to be an incidental aneurysm at the origin of the (L) posterior communicating artery.
(12B) In addition to the midline frontal hematoma, a discrete round area of enhancement suggests an aneurysm of the anterior cerebral artery at the level of the genu of the corpus callosum. This aneurysm was identified at angiography and at surgery showed evidence of recent rupture. This case shows how CT accurately localize the site of bleeding in a patient with multiple aneurysms.

Arteriovenous Malformations

Patients with long standing vascular type headaches with or without seizure activity and a negative or equivocal neurological examination are seen frequently in any type of medical practice. Arteriovenous malformations are often suspected in these patients, yet it is difficult to determine which patients should be subjected to invasive procedures such as cerebral angiography. The traditional diagnostic work up of plain skull films, electroencephalography and radionuclide brain scan is relatively insensitive to small or deep lying malformations. Pre and post infusion CT scans now provide a safer way to identify patients with structural basis for headaches or seizures.

Precontrast scans in patients with AVM may be normal or may show a variety of focal abnormalities including calcifications or focal atrophy. After contrast infusion, the enlarged feeding vessels and draining veins may be identified, along with the malformation nidus itself.

This case involved a 53-year-old female brought to the Emergency Room complaining of severe headache, diplopia, and increasing confusion. Progressive lethargy and disorientation followed. A CT scan revealed an arteriovenous malformation (Figure 15).

FIGURE 15. (1A & 1B) Post infusion scan shows a mass of dense enhancement in the (L) medial temporo-occipital area. Discrete serpentine structures are seen about the abnormal area, one of which passes forward

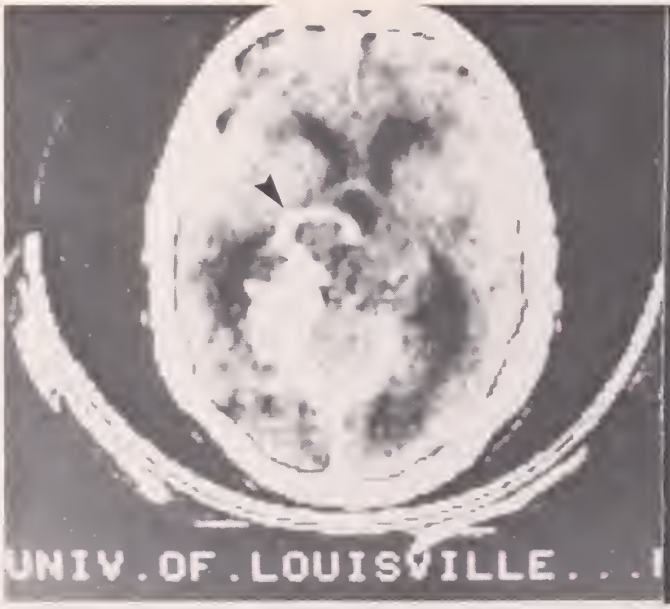

Fig. 15. 1A

Fig. 15. 1B

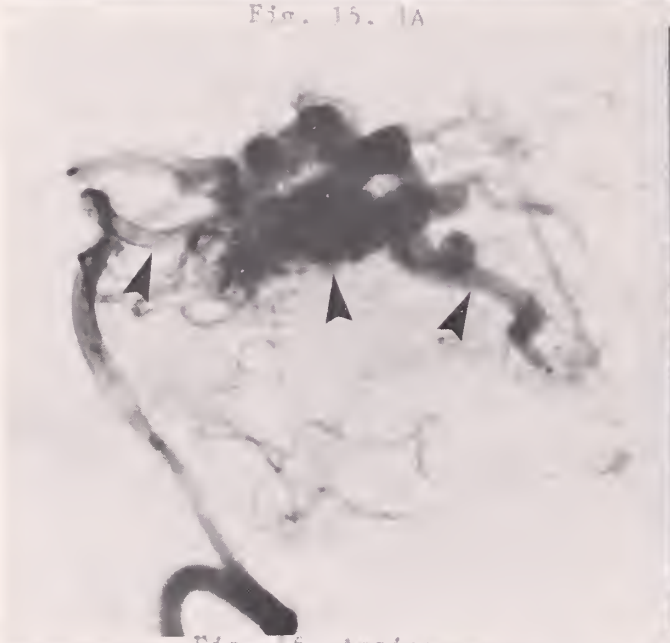

Fig. 15. Angiogram

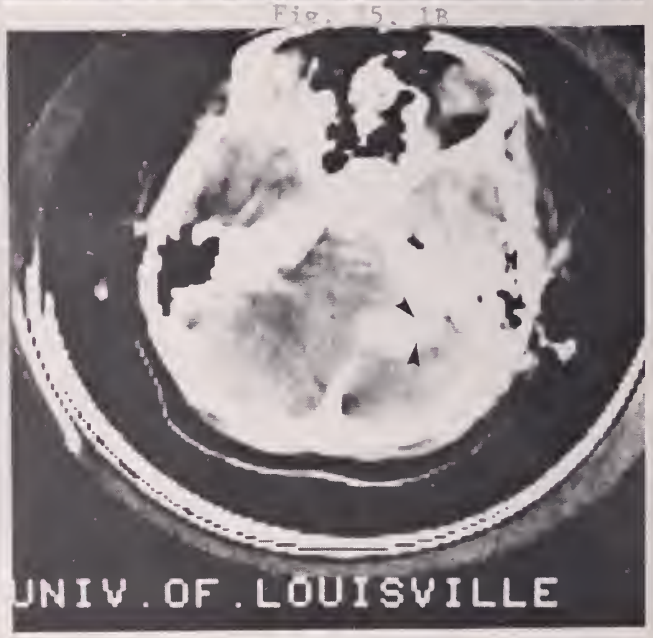

Fig. 16. 2B

Fig. 16. 3A

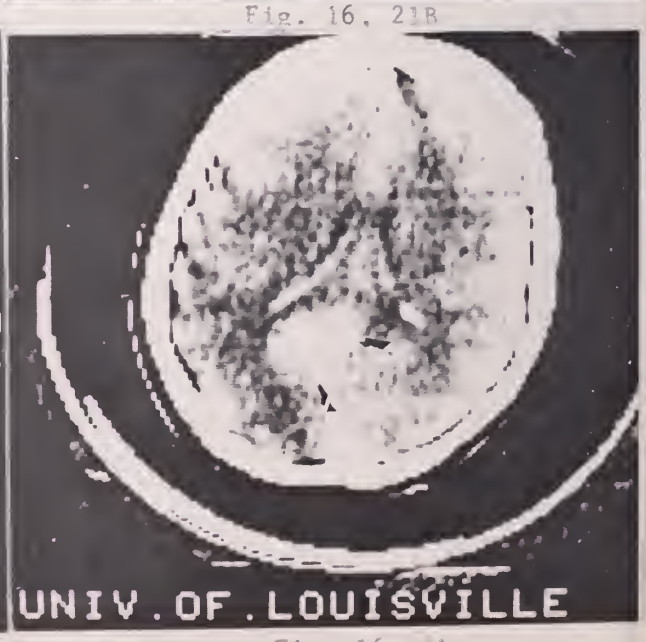

Fig. 16. 4A

Fig. 17. 1B

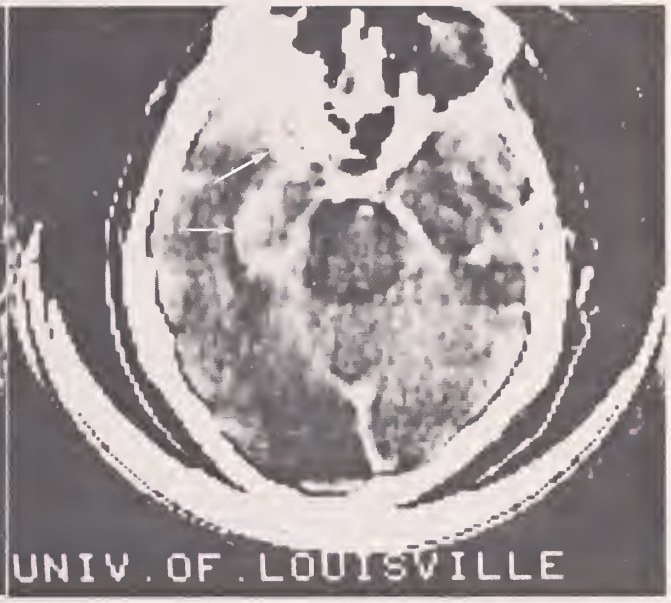

Fig. 17. 2A

towards the third ventricle. The dense enhancement, sharp margins and curvilinear configuration suggest that these are vascular structures. A moderate communicating hydrocephalus is present secondary to subarachnoid hemorrhage. (Angiogram) A single lateral film from the vertebral angiogram shows an enlarged feeding posterior cerebral artery and enormous tortuous draining veins, characteristic of an arteriovenous malformation.

Traumatic Hemorrhage Lesions

Intracerebral hemorrhage following trauma may manifest as a diffuse patchy area of edema and hemorrhage, cerebral contusion or a discrete collection of clotted blood (intracerebral hematoma). Each may exert considerable mass effect and produce life threatening neurological depression. Precise localization of such lesions is difficult with angiography. Angiography is particularly poor at identifying bilateral hemorrhagic mass lesions or distinguishing contusion and edema from hematoma. These features are easily seen with the CT scan. CT scanning is the quickest, safest, and most accurate diagnostic tool for the evaluation of the patient with acute head injury, and is the procedure of choice at the University of Louisville Health Sciences Center.

A 26-year-old female was brought to the Emergency Room with a gunshot wound to the back of the head. Neurological manifestation included increasing lethargy, weakness, and decreasing responsiveness. A CT scan revealed an intracerebral hemorrhage (Figure 16).

FIGURE 16. (21B) A fine cluster of metallic fragments are embedded in the lower right cerebellar hemisphere. The high density area represents an intracerebral hemorrhage along the gunshot wound track extending superiorly into the upper vermis.
(3A & 4A) Subarachnoid hemorrhage is seen outlining the quadrigeminal plate cistern and interhemispheric fissure. The hemorrhage along the missile path involves many structures above and below the tentorium and spares the brain stem. Surgical evacuation was not felt to be indicated due to the inaccessible location of the hemorrhage.

Herpes Simplex Encephalitis

Herpes simplex encephalitis is a hemorrhagic necrotizing inflammatory process which predominately affects the base of the brain, especially the under surface of the temporal lobe.[8] Clinical presentation is protean, including behavior disorder, hemiplegia, or even coma. The inflammatory mass may produce considerable pressure on the brain stem and adjacent structures, and may be difficult to distinguish clinically or angiographically from brain tumor or intracerebral hemorrhage.

A 56-year-old male was admitted to the hospital with increasing lethargy, weakness, and severe headache. The neurological manifestations included a mild weakness of the left extremities, slight expressive aphasia, and disorientation. A CT scan revealed findings of hemorrhagic encephalitis predominately in the left temporal lobe (Figure 17).

FIGURE 17. (1B) A non-infused scan shows a cur-

vilinear area of high density outlining the anterior and medial surface of the (L) temporal lobe. There is also a deep area of low density or edema involving the temporal lobe centrally. The superficial density involves the insular cortex as well.

(21A) Post-infusion scan shows a gyral type enhancement involving the horizontal and insular portion of the (L) sylvian fissure contiguous to the area of high density. The high density component is representative of the hemorrhagic nature of herpes simplex encephalitis.

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GRAND ROUNDS

University of Kentucky College of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

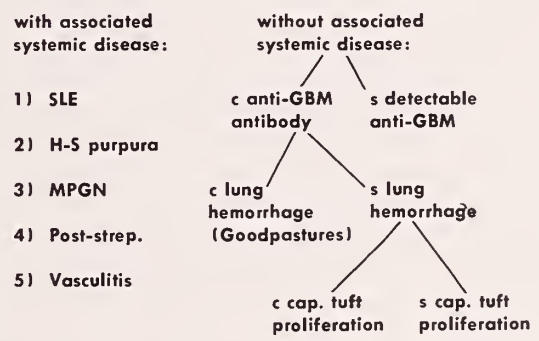
Rapidly Progressive Glomerulonephritis

When patients are seen with acute renal failure the diagnosis often is so called "acute tubular necrosis" (ATN). Indeed, ATN is so frequently the cause of acute renal failure (ARF) that, in the past, some physicians have employed incorrectly the terms as synonyms. The pathophysiology, exact anatomic location of renal damage, and the mechanisms of injury involved in ATN remain debated but the clinical entity is well defined.[1] In our discussion today two important facts should suggest that we are dealing with a patient who has acute renal failure on a basis other than ATN: 1) The patient's renal failure seems to have developed spontaneously; i.e., without any easily identifiable cause, and 2) The patient's renal failure developed outside a hospital setting. On the other hand, ATN is usually seen in patients who have easily recognized possible causes; indeed, such patients often have multiple possible causes. Moreover, ATN tends frequently (but not always) to develop in hospital settings such as after surgery, following blood transfusions or obstetric procedures.

A patient who developes acute intrinsic renal failure outside the hospital and without any of the recognized causes of ATN ascertained in history is likely to have acute renal failure involvement of one of the two other possible anatomical sections of the kidney: 1) The small blood vessels, as in malignant hypertension, polyarteritis or scleroderma, or 2) The glomeruli, as in post-streptococcal glomerulonephritis or so-called rapidly progressive glomerulonephritis. Examination of the urine is very helpful in diagnosing acute renal failure due to acute glomerular disease. Such patients usually have marked protein, red blood cells, white blood cells, and cellular casts in their urine. The patient presented today had such a urinalysis and the diagnosis of rapidly progressive glomerulonephritis (RPGN) was confirmed by renal biopsy.

Table

GENERAL CLASSIFICATION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS



RPGN is a disease process of unknown etiology (but felt to be mediated by immune mechanisms) in which the renal glomeruli are the primary site of injury and renal failure develops in a time period of days to weeks. Morphologic examination of kidney tissue reveals so-called "crescents" in the glomerular structure. Untreated, the prognosis is extremely poor; however, the beneficial effects of the various proposed treatments remain unproven by controlled trials. As in many renal diseases, the terminology associated with RPGN is both confused and confusing. First we will briefly consider terminology and then discuss the clinical features, histologic findings,

From the
Department of Medicine
University of Kentucky Medical Center
Lexington, Kentucky

possible immune mechanisms, and finally the proposed treatments.

"Rapidly" and "progressive" are terms which connote time, thus from a purely clinical standpoint, any primary glomerulonephritis that evolves quickly to renal failure would be RPGN. However, the term RPGN, as originally coined by Bacani et al,[2] is more specific in that it implies a clinical course associated with a specific histologic pattern of renal damage, a non-streptococcal origin, and a poor prognostic outcome. Unfortunately, the clinical course of RPGN can be seen in diseases that do not usually have the specific histologic pattern; e.g., post-streptococcal glomerulonephritis or hemolytic uremic syndrome. The histologic pattern (crescents) can be seen in renal diseases that have different clinical courses and prognosis; e.g., Henoch-Schonlein purpura, systemic lupus erythematosis or membranoproliferative glomerulonephritis. Moreover, nephrologists often use the terms RPGN, crescentic glomerulonephritis, extracapillary epithelial proliferated glomerulonephritis, and anti-glomerular basement antibody disease as synonyms. One possible method of considering the terminology of RPGN is to employ the term as a general category for renal diseases in which there is rapid renal failure and a histologic pattern of crescents (see Table). On the other hand, one could be extremely specific and reserve the use of the term RPGN for only those cases of rapid renal failure and crescentic histology in which other associated diseases are not present, there is no lung hemorrhage, and no glomerular endocapillary cell proliferation. It is important, especially in considering the literature of therapy trails, to recognize the difficulties of uniform terminology.

Perhaps there is more general agreement concerning the clinical course of RPGN than the terminology. The disease seems to be one of older men,[2,3] but may occur in women, and at any age. The onset is characterized often by an acute nephritic syndrome, and in many cases the patient quickly becomes oliguric. Symptoms of an upper respiratory infection are said to proceed the onset of renal failure in up to 25% of cases and exposure to hydrocarbons is also sometimes found in the history (such symptoms and exposure to hydrocarbons, however, are frequent in the general population and not necessarily causes of the disease). The disease is relatively rare (at UKMC we have seen 22 cases in the last five years), another fact which, along with the terminology difficulties, makes study of therapy difficult. Presenting symptoms are usually those of renal failure; i.e., uremic symptoms and/or fluid overload. The urinalysis is positive for protein, RBCs and WBCs. Serum complement is normal. Interestingly, despite the renal failure and oliguria, such patients are often not hypertensive. Untreated, renal function rarely, if ever, recovers.

Histologic examination of kidney tissue reveals a glomerular disease, the hallmark being so-called "crescents." Bowman's capsule is normally lined with epithelial cells. In RPGN these epithelial cells are increased in number and form a crescent shaped structure that appears to surround and compress the glomerular tuft. Electron microscopic examination of glomerular capillary reveals breaks and gaps in the basement membrane along with areas of thrombosis. In some cases there is also mild proliferation of the other cells of the glomerulus, but in other cases only the epithelial cells of Bowman's capsule have proliferative changes. The number of glomeruli with crescents and the shape and size of the crescents have been said to relate to prognosis. Over 70% crescents, circumferential crescents, and lack of proliferation of the other cell lines of the glomerulus are considered especially poor prognostic features.[4]

Immunofluorescent microscopic study revealed two important features: 1) Fibrin is often detected in the crescents, 2) IgG and complement are often deposited along the glomerular basement membrane in a so-called "linear fashion."

That the mechanism of this disease is related to antibodies directed against the basement membrane of the glomerular capillary has been shown convincingly by McPhaul et al.[5] Exactly why patients develop such antibodies, however, remains uncertain.[6]

Kincaid-Smith proposed therapy for this disease with anticoagulation[7] because of the fibrin noted on immunofluorescent studies. Johnson et al[8] have proposed therapy with plasmaphoresis (exchange transfusion) to remove the anti-GBM antibodies from circulation. There are numerous case reports of recovery with these treatments given in combination with immunosuppressive agents such as cyclophosphamide and azathioprine.[8,9] Because of the difficulties of terminology, the rareness of the disease, and the difference of opinion regarding which histologic features predict the poorest outcomes, it has been difficult to construct a single center controlled trial of any of the treatments proposed. In addition to the

histologic features previously discussed that predict poorer outcomes, the finding of oliguria, and initiation of treatment late in the course of the disease also are associated with lack of recovery.[8,10]

Patients who have developed end stage renal failure due to RPGN have been treated with both chronic dialysis and renal transplantation. Of interest is the obser ation that the immunologic features of RPGN can recur in the allograft. Couser et al[11] report two cases in which antiglomerular basement membrane (anti GBM) antibody was present in the serum and allograft of patients whose original disease was RPGN, but neither developed progressive renal failure. Most transplant centers wait for serum levels of anti GBM to disappear before transplantation.

In summary, RPGN is a glomerulonephritis that causes acute renal failure. Its etiology, while not completely understood, seems to be related to circulating antibodies that react with kidney glomerular basement membrane. Numerous crescents, oliguria, late presentation, and lack of endocapillary proliferation or other associated diseases are all poor prognostic features. Recently, anticoagulation, immunosuppression, and plasmaphoresis have been suggested as treatments. Good results have been obtained, but controlled trials of these treatments are still pending. Renal biopsy and tests for serum anti GBM antibody should be available before considering these forms of therapy.

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JOHN J. CURTIS, M.D.

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Members of the Kentucky Medical Association reading papers before other organizations are asked to submit their papers to *The Journal* for consideration by the Editors for publication. Detailed instructions to contributors appear in the Scientific Section of *The Journal* under Manuscript Memos. Please forward any papers to:

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MATERNAL MORTALITY

From the Files of the KMA Maternal Mortality Study Committee

—Edited by John W. Greene, Jr., M.D.

9-76. A 25-year-old, single, white, gravida 2, para 1, was seen in the emergency room of a 260-bed general hospital at 11:05 a.m., 5-25-76, complaining of severe pelvic pain; the patient was semi-comatose at the time. Difficulty was encountered in obtaining a detailed history. A past history of epilepsy was revealed but it was not known whether the patient was presently receiving medication or had received any past treatment for this condition. The patient was admitted to ICU and complained of a severe headache and dizziness. Upon further examination a vaginal discharge was detected. Her pupils were dilated and prior to admission she convulsed. It was further determined that the patient was pregnant and had her first prenatal visit one month ago. It was ascertained that penicillin had been administered two weeks earlier for a diagnosis of tonsillitis.

Laboratory data was as follows: SBC 12,000 with 70% polys, blood sugar 229, urine sugar negative, acetone positive, blood gas ph 1.43, total CO_2, BUN 7, total protein 6.4, osmolarity 294, x-ray of the skull was normal. A neurosurgical consultant found she responded when spoken to, her left pupil was larger than the right and she experienced a weakness of the right side.

She received supportive treatment, but shortly after admission she arrested. She was resuscitated but remained in a coma and expired at 10:25 p.m. An autopsy was performed.

The uterus was found to be intact; the fetus, a male, weighed 910 grams. Examination of the brain revealed a huge neoplasm in the left cerebrum and extended across the midline to infiltrate the right cerebrum. It revealed areas of hemorrhage and degeneration as well as cystic change. The third ventricle was greatly dilated and the pons revealed areas of marked congestion and hemorrhage compatible with hernicition of the brain stem.

The final diagnosis was a massive diffuse infiltrating glioma, grade 2. The cause of death was considered due to the massive glioma. The fetus was considered to have been about 6½ months gestation.

Comment

The Committee on Maternal Mortality classified this case as an indirect obstetrical non-preventable case. It is presented to the readers of *The JOURNAL* to emphasize that such disease can occur in young women. It emphasizes that such a massive lesion can be present with few or no symptoms until late in the disease. It further emphasizes that her history of seizures could well have been related to the tumor. This is another example of a situation where the treatment, if it had been possible, should have been undertaken even in the presence of a pregnancy.

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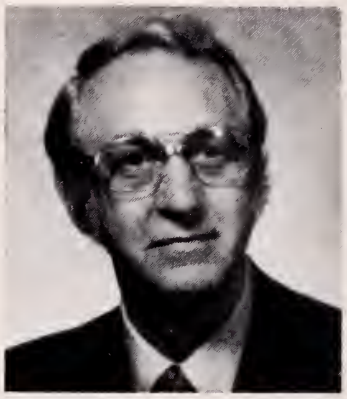

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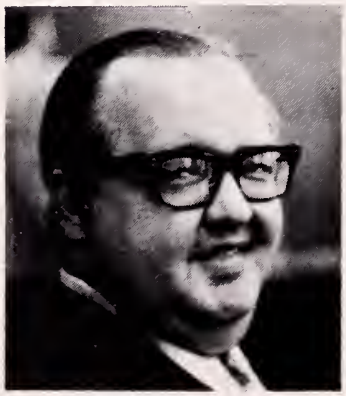

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PRESIDENT-ELECT
Carl Cooper, Jr., M.D.
Bedford

Carl Cooper, Jr., M.D., will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 27.

A family physician, Doctor Cooper received his medical degree in 1952 from the University of Louisville, and served his internship at Louisville General Hospital. Doctor Cooper is on the active staff at Carroll County Memorial Hospital in Carrollton, Kentucky.

Before his election as President, Doctor Cooper served the Association as House Speaker, Vice-Speaker, Vice President, and Alternate Delegate to AMA. He also was Chairman of KEMPAC.

Doctor Cooper is a Fellow of the American Academy of Family Physicians. Having served as Vice-President and Director of the Kentucky Academy of Family Practice, Doctor Cooper received that organization's 1971 Citizen Doctor of the Year award.

Long active in community and civic service, Doctor Cooper was a member of the Trimble County Board of Education for 12 years, is a Past President of the Bedford Rotary Club, and the Trimble County Development Association.

VICE-PRESIDENT
Robert S. Howell, M.D., Louisville

Doctor Howell, a pathologist, is associated with the University of Louisville School of Medicine, from which he graduated in 1952. He is a Fellow in the College of American Pathologists and the American Society of Clinical Pathologists. A Past President of the Jefferson County Medical Society, Doctor Howell also has served as Vice-President of KMA. He received the AMA 1976-79 Distinguished Physicians award. Doctor Howell was the 1974 President of the Kidney Foundation of Kentucky, and is active in the Chamber of Commerce.

SECRETARY-TREASURER
S. Randolph Scheen, M.D., Louisville

Doctor Scheen was KMA Secretary for eight years prior to his election as Secretary-Treasurer in 1975. A dermatologist, he is a graduate of the University of Louisville and University of Minnesota medical schools. Doctor Scheen serves the Association as a member of the Budget Committee, Judicial Council, and the Ad Hoc Committee on the Overview of the KMA Peer Review Activities. He is a member of the American Academy of Dermatology and the Alumni Foundation of the Mayo Clinic, and is a regular participant on local television and radio programs, answering questions from the public on dermatology.

SPEAKER OF THE HOUSE
Bennett L. Crowder, II, M.D., Hopkinsville

Doctor Crowder served an unexpired term of one year as Vice-Speaker, and also serves as Parliamentarian for the Association. A general and thoracic surgeon, he is a 1961 graduate of the University of Tennessee, and currently is the Director of the Pennyrile Emergency Medical Service. A Fellow in the American College of Surgeons, Doctor Crowder also sits on the Constitution and Bylaws Committee of KMA and is Secretary of the KEMPAC Board. He is active in numerous civic organizations, including the Jaycees, Rotary Club, and the Chamber of Commerce.

VICE-SPEAKER OF THE HOUSE
Peter C. Campbell, Jr., M.D., Louisville

An ophthalmologist, Doctor Campbell is Clinical Professor of Ophthalmology at the University of Louisville School of Medicine. He is a member of the American Academy of Ophthalmology and Otolargynology, the Kentucky Academy of Eye Physicians and Surgeons, and is President-Elect of the medical staff at Methodist Evangelical Hospital in Louisville. Doctor Campbell is a 1961 graduate of the University of Louisville School of Medicine.

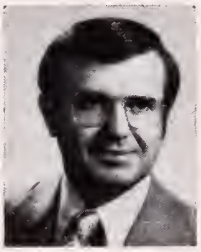
AMA Delegates

David B. Stevens, M.D., Lexington

Doctor Stevens is the Senior Delegate to the AMA from Kentucky, having served since 1965 as Delegate or Alternate Delegate. An orthopedic surgeon, he is active in the field of cults, both locally and at the national level. Doctor Stevens is a Past President of the Fayette County Medical Society, and served eight years on the KMA Committee on Legislative Activities. A 1955 graduate of Northwestern University, Doctor Stevens is Assistant Clinical Professor of Surgery at the University of Kentucky.

Fred C. Rainey, M.D., Elizabethtown

Doctor Rainey was elected an AMA Delegate in 1974, having previously served as President of KMA, Alternate AMA Delegate, and Board Chairman of KEMPAC. A 1955 graduate of the University of Tennessee College of Medicine, Doctor Rainey is a family physician. He is a member of the AMA Council on Legislation, the American Medical Political Action Committee, the Kentucky Academy of Family Physicians, and the American Academy of Family Physicians.



Harold D. Haller, Sr., M.D., Louisville

Elected an AMA Delegate in 1976, Doctor Haller has been active on the Committee on Maternal and Child Health and the Committee on Health Care Costs. Doctor Haller graduated in 1963 from Bowman Gray Medical School, and has been in family practice since then. A charter member of the American Board of Family Practice, Doctor Haller also has served as President of the Kentucky Chapter of the American Academy of Family Physicians.

Journal Editors

EDITOR

A. Evan Overstreet, M.D., Louisville

Before Doctor Overstreet became Editor of *The Journal* last September, he had served on the Editorial Board for over six years. An internist, Doctor Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, and the Transylvania Medical Society.

Milton F. Miller, M.D., Louisville

Doctor Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Doctor Miller has served on the Membership Committee of the Jefferson County Medical Society. He is a 1954 graduate of the University of Louisville.

G. Randolph Schrodt, M.D, Louisville

Doctor Schrodt has served as Assistant Editor since 1974. A 1954 graduate of the University of Louisville School of Medicine, Doctor Schrodt is a pathologist, and is Professor and Chairman of the Department of Pathology at the University of Louisville School of Medicine. He is a member of the American Society of Clinical Pathologists and the International Academy of Pathology.

David L. Stewart, M.D., Louisville

Doctor Stewart, a former Editor of the Jefferson County Medical Society *Bulletin*, is in his second year as Assistant Editor of *The Journal*. A psychiatrist, Doctor Stewart graduated from the University of Louisville in 1946, is a member of the American Psychiatric Association, and is Chairman of the KMA Committee on Physicians' Health.

James P. Moss, M.D., Louisville

Serving his first year as Assistant Editor, Doctor Moss is a surgeon and Assistant Clinical Professor, Department of Surgery at the University of Louisville School of Medicine. A diplomate of the American Board of Surgery, Doctor Moss is active in the Jefferson County Medical Society and KMA. He graduated from the University of Louisville School of Medicine in 1966.

Other Editorial Positions

Scientific Editor

Paul C. Grider, Jr., M.D., Louisville—Appointed in 1974.

Assistant Scientific Editor

Stephen Z. Smith, M.D., Louisville—Appointed in 1977.

Regional Editors—Appointed in 1977

Allen E. Grimes, Jr., M.D., Lexington
William W. Hall, M.D., Owensboro
Thomas L. Heavern, Jr., M.D., Highland Heights

New Trustees

Wally O. Montgomery, M.D., Paducah

Doctor Montgomery serves as Trustee from the First District. A surgeon, Doctor Montgomery is a 1962 University of Louisville School of Medicine graduate. He was Board Chairman of KEMPAC, and was an AMA Alternate Delegate from Kentucky. Doctor Montgomery is a diplomate of the American Board of Surgery, and is a member of the Southeastern Surgical Society.

Harvey A. Page, M.D., Pikeville

Doctor Page now serves as the Fourteenth District Trustee. He is a 1957 graduate of the University of North Carolina School of Medicine, and is in family practice. He is a member of the Academy of Family Practice.

Number to Use for Messages is 606-233-4111

A Message Center will be set up during the 1978 KMA Annual Meeting. The telephone number where you may be reached is 606-233-4111. This is a central hotel number through which all messages will be routed.

The Message Center will be located inside the Convention Center at the mall entrance.

OFFICIAL CALL
KMA Annual Meeting

To the officers and members of the component county medical societies of the Kentucky Medical Association.

Meeting Place

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 26, 27, and 28, at the Lexington Convention Center, Lexington. The first general session will be called to order at 8:30 a.m., Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 9 a.m., Monday, September 25, in the Regency Ballroom of the Hyatt Regency/Lexington Convention Center. The second regular business session will begin at 6 p.m., Wednesday, September 27, in the Regency Ballroom of the Hyatt Regency/Lexington Convention Center.

Registration

The registration desk will open for Delegates in the Hyatt Regency foyer at 8 a.m., Monday, September 25 and at 5 p.m., Wednesday, September 27. General registration will be held at the entrance to the Technical Exhibits Hall from 8 a.m. to 5 p.m., Tuesday and Wednesday, and 8 a.m. to 3:30 p.m. on Thursday.

U. L. Alumni Reunions Planned During AMA Annual Meeting

Eight classes of the University of Louisville School of Medicine are planning reunions for alumni. The reunions are scheduled to be held during the KMA Annual Meeting, September 26-28.

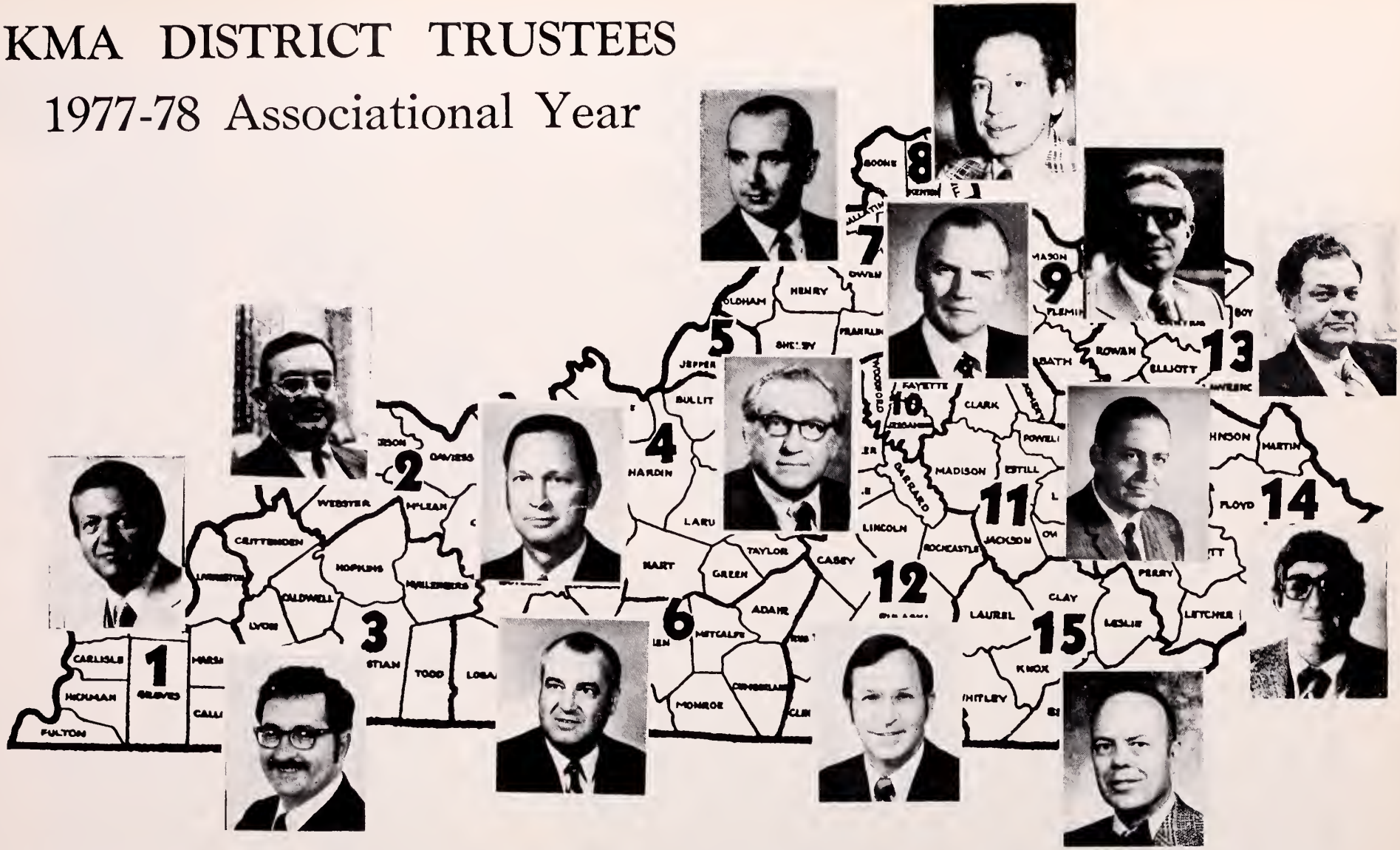
Chairman of the classes are listed below. Information regarding the reunions may be obtained by contacting the Chairman or the U of L Alumni Office (502) 588-5783.

All alumni, spouses, and guests are invited to attend the third annual U of L Medical School Alumni Reception, to be held Tuesday, September 26, at the Lexington Hyatt Regency. The reception will be poolside from 5 to 7 p.m.

Year	Chairman	Date	Time	Place
1928	Hugh Mahaffey, M.D.	Sept. 26	7:30 p.m.	Levas Restaurant, Lexington, Ky.
1933	Ethel H. O'Brien, M.D.	Sept. 28		Audubon Country Club, Louisville, Ky.
1938	Glenn W. Bryant, M.D.	Sept. 26	7:00 p.m.	Big Spring Country Club, Louisville, Ky.
1948	Robert S. Heidt, M.D.		8:00 p.m.	Levas Restaurant, Lexington, Ky.
1953	James I. Salter, M.D.	Sept. 27		Levas Restaurant, Lexington, Ky.
1958	Morris M. Weiss, M.D.	Sept. 26	7:00 p.m.	Levas Restaurant, Lexington, Ky.
1963	Morton Kasdan, M.D.	Sept. 26		Lafayette Club, Lexington, Ky.
1973	Charles S. Smith, M.D.	Sept. 23	6:00 p.m.	Executive Inn, Louisville, Ky.

KMA DISTRICT TRUSTEES

1977-78 Associational Year



1. WALLY O. MONTGOMERY
Paducah

2. R. J. PHILLIPS
Owensboro

3. FRANK R. PITZER
Hopkinsville

4. CHARLES B. SPALDING
Bardstown

5. CECIL L. GRUMBLES
Louisville

6. EARL P. OLIVER*
Scottsville

7. WILLIAM H. KELLER
Frankfort

8. RICHARD J. MENKE
Covington

9. DON R. STEPHENS
Cynthiana

10. JAMES B. HOLLOWAY, JR.†*
Lexington

11. DWIGHT L. BLACKBURN*
Berea

12. WILLIAM T. WATKINS
Somerset

13. HOWARD B. McWHORTER
Ashland

14. HARVEY A. PAGE
Pikeville

15. HAROLD L. BUSHEY*
Barbourville

*Member, KMA Executive Committee
†Chairman, KMA Board of Trustees

KMA DELEGATES

ADAIR
Millard C. Loy, Columbia

ALLEN
Earl P. Oliver, Scottsville

ANDERSON
H. Boyd Caudill, Lawrenceburg

BALLARD

BARREN
Howard L. Edgin, Glasgow

BATH

BELL

BOONE
William M. Waller, Walton
William R. Yates, Hebron

BOURBON

BOYD

BOYLE

BRACKEN
J. M. Stevenson, Brooksville

BREATHITT
H. Price Sewell, Jackson

BRECKENRIDGE

BULLITT
W. Bruce Hamilton, Shepherdsville

BUTLER
Richard T. Wan, Morgantown

CALLOWAY
R. Gary Marquardt, Murray

CAMPBELL-KENTON

CARLISLE

CARROLL
Cecil D. Martin, Carrollton

CARTER

CASEY
Lewis E. Wesley, Liberty

CLARK

CLAY
W. E. Becknell, Manchester

CLINTON
Floyd B. Hay, Albany

CRITTENDEN
Westel L. Creager

CUMBERLAND

DAVIESS

EDMONSON

ELLIOTT

ESTILL

FAYETTE
Harry L. Bailey, Lexington
Leslie W. Blakey, Lexington
Walter R. Brewer, Lexington
P. Raphael Caffrey, Lexington
D. Kay Clawson, Lexington
Marcus L. Dillon, Lexington
Glenn U. Dorroh, Lexington
Ward O. Griffen, Jr., Lexington
Allen E. Grimes, Jr., Lexington
Ronald D. Hamilton, Lexington
Walter D. Harris, Lexington
Franklin B. Moosnick, Lexington
Charles H. Nicholson, Lexington
Edwin J. Nighbert, Lexington
John D. Perrine, Lexington

FLEMING

FLOYD
W. Grady Stumbo, Hindman

FRANKLIN

FULTON

GALLATIN

GARRARD
Paul J. Sides, Lancaster

GRANT
R. Michael Goodman, Williamstown

GRAVES
Donald C. Haugh, Mayfield

GRAYSON
Charles L. Bland, Leitchfield

GREEN

GREENUP

HANCOCK

HARDIN

HARLAN
Paul M. Walstad, Harlan
Milo H. Schosser, Benham

HARRISON
A. C. Wright, Cynthiana

HART
Keene M. Hill, Horse Cave

HENDERSON
Kenneth M. Eblen, Henderson
John W. McClellan, Henderson

HICKMAN
C. J. Mills, Clinton

HOPKINS
James G. Gulley, Madisonville

JACKSON
Philip R. Curd, McKee

JEFFERSON
W. Stephen Aaron, Louisville
Hugh P. Adkins, Louisville
Joseph C. Babey, Louisville
James G. Baker, Louisville
David H. Bizot, Louisville
Harold W. Blevins, Louisville
Joseph R. Bowling, Louisville
Charles M. Brohm, Louisville
Glenn W. Bryant, Louisville
John L. Bunting, Louisville
Peter C. Campbell, Jr., Louisville
E. Dean Canan, Louisville
Ronald G. Chism, Louisville
Clinton C. Cook, II, Louisville
Donne O. DeMunbrun, Louisville
E. Kathie Elliott, Louisville
John M. Farmer, Louisville
Paul A. Fleitz, Louisville
James W. Forrester, Louisville
Gary Fox, Louisville
Henry D. Garretson, Louisville
John J. Guarnaschelli, Louisville
Harold D. Haller, Louisville
Claude C. Hazlett, Louisville
Terry W. Henkel, Louisville
Lonnie W. Howerton, Louisville
Richard K. Jelsma, Louisville
Ferrell C. Lowrey, Jr., Louisville
Theodore N. Lynch, Louisville
H. Burl Mack, Pewee Valley
Thomas M. Marshall, Louisville
Roy J. Meckler, Louisville
Charles R. Oberst, Louisville
C. Ray Potts, Louisville
Carroll H. Robie, Louisville
David C. Shipp, Louisville
Charles C. Smith, Jr., Louisville
Thomas G. Stigall, Louisville
Donald T. Varga, Louisville
William E. Yancey, Louisville

JESSAMINE
Phyllis J. Corbitt, Wilmore

JOHNSON
Joseph H. Rapier, Jr., Prestonburg

KNOTT
Gene T. Watts, Hindman

KNOX
Rufino F. Cristostomo, Barbourville

LARUE

LAUREL

LAWRENCE

LEE
Arnold L. Taulbee, Beattyville

LESLIE
W. B. R. Beasley, Hyden

LETCHER
Vincent C. Arroz, Whitesburg

LEWIS

LINCOLN
Charles E. Crase, Stanford

LIVINGSTON
Stephen Burkhart, Salem

LOGAN

MADISON
Don E. Cloys, Richmond
Linda S. Fagan, Richmond

MAGOFFIN

MARION
John W. Ratliff, Lebanon

MARSHALL
Keith E. Ellis, Benton

MARTIN
Raymond D. Wells, Inez

MASON

McCRACKEN

McCREARY
H. A. Perry, Whitley City

McLEAN
Hugh H. Wilhite, Calhoun

MEADE

MENIFEE

MERCER
Bacon R. Moore, III, Harrodsburg

METCALFE
L. P. Emberton, Edmonton

MONROE

MONTGOMERY

MORGAN
James D. Frederick, West Liberty

NELSON
Kenneth L. Stinnette, Bardstown

NICHOLAS
Allen J. Hamon, Carlisle

OHIO
Robert E. Norsworthy, Hartford

OWEN
O. A. Cull, Owenton

OWSLEY
Carl W. Noble, Booneville

PENDLETON
Robert L. McKenney, Falmouth

PENNYRILE
Caldwell: N. H. Talley, Princeton
Christian: Carl B. Caplinger, Hopkinsville; James H. Simpson, Hopkinsville
Lyon: Alex A. Zegarra, Eddyville
Muhlenberg: William L. Miller, Greenville
Todd: Larry O. Brock, Elkton
Trigg: W. N. Richardson, Cadiz

PERRY
Donnie R. Spencer, Hazard

PIKE
Charles G. Nichols, Pikeville

POWELL

PULASKI

ROBERTSON

ROCKCASTLE
George W. Griffith, Mt. Vernon

ROWAN

RUSSELL
Charles E. Peck, Russell Springs

SCOTT
Gus A. Bynum, Georgetown

SHELBY-HENRY-OLDHAM

SIMPSON
J. M. Pulliam, Franklin

SPENCER
William K. Skaggs, Taylorsville

TAYLOR
Henry F. Chambers, Campbellsville

TRIGG
Eduardo Pavon, Cadiz

TRIMBLE
Carl Cooper, Jr., Bedford

UNION

WARREN

WAYNE
John W. Simmons, Monticello

WEBSTER

WHITLEY
R. D. Pitman, Williamsburg

WOLFE
Paul F. Maddox, Campton

WOODFORD
Lewis E. Wash, Lawrenceburg

Reference Committee Activity

Speaker Bennett L. Crowder, II, M.D., Hopkinsville, will assign all officers' and committees' reports and resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9 a.m., Monday, September 25. **Briefing sessions** for Reference Committee Chairmen will be held at **12:30 p.m., Monday,** in the Mary Todd Lincoln Room of the Hyatt Regency Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the **Reference Committee meetings** which will be held at **2 p.m., Monday, September 25** at Lexington Convention Center, Meeting Rooms A through F. These open sessions will last one hour, in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final session of the House, Wednesday evening, September 27, in the Regency Ballroom, Hyatt Regency.

As Speaker of the House of Delegates, Doctor Crowder is in the process of finalizing appointments to the six Reference Committees, Credentials Committee, and Tellers Committee.

If your society has not yet submitted the names of your Delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of these important committees.

A complete listing of members who will be serving on the six Reference Committees and the location of the Reference Committee meetings will be published in the *September issue of the KMA Journal.*

Anyone desiring names of Reference Committee members prior to the September issue being published should contact the Headquarters Office.

ELECTIONS

Election of Trustees and Alternate Trustees

The House of Delegates will elect six District Trustees and five Alternate Trustees at its second regular session, Wednesday, September 27. Nominations will be made by the Delegates from the electing Districts at a meeting following the first session of the House on Monday, September 25.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 26. Further nominations may be made from the floor at the final session of the House on Wednesday evening, September 27. All nominations are considered and acted upon by the Delegates at this final session.

Districts electing Trustees for three year terms are: **FIFTH DISTRICT** (incumbent, Cecil L. Grumbles, M.D., Louisville); **SIXTH DISTRICT** (incumbent, Earl P. Oliver, M.D., Scottsville); **EIGHTH DISTRICT** (incumbent, Richard J. Menke, M.D., Crestview Hills); **ELEVENTH DISTRICT** (incumbent, Dwight L. Blackburn, M.D., Berea); and the **FIFTEENTH DISTRICT** (incumbent, Harold L. Bushey, M.D., Barbourville). In addition, the Tenth District will select a Trustee to fill one year of the unexpired three-yearterm of James B. Holloway, Jr., M.D., who has submitted his resignation as Tenth District Trustee.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are Glenn W. Bryant, M.D., Louisville (5th); L. Martin Wilson, M.D., Bowling Green (6th); Robert C. Smith, M.D., Newport (8th); Don E. Cloys, M.D., Richmond (11th); and Walter H. Stepchuck, M.D., Harlan (15th).

Trustees and Alternates from the 5th, 6th, 8th, and 11th Districts are eligible for re-election, while both the Trustee and Alternate Trustee from the 15th District have served two full terms and are not eligible for re-election.

House to Elect New Officers During Annual Meeting

KMA Officers for the 1978-79 Associational year will be elected by the House of Delegates at the close of its final session, Wednesday evening, September 27. Officers to be elected from the state at large are as follows:

Officer	Term
President-Elect	**One Year**
Vice President	**One Year**
Secretary-Treasurer	**Three Years**
Delegate to the AMA (1)	**Two Years**
***Harold D. Haller, Sr., M.D.**	
Alternate Delegate	**Two Years**
***Kenneth P. Crawford, M.D.**	

***Incumbent**

The AMA Delegate and Alternate are to be elected for two-year terms from January 1, 1979, to December 31, 1980.

Nominating Committee to Meet Monday, September 25

The KMA Nominating Committee will hold an open meeting at the close of the first session of the House of Delegates, Monday, September 25, in the Regency Ballroom, Hyatt Regency Hotel.

Any KMA member may confer with the Committee during this meeting. Final recommendations of the Committee will be reported at the end of the first scientific session, Tuesday morning, September 26.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, September 27. The House will vote on the nominees at the close of this session.

Members of the Committee are as follows: Thomas M. Marshall, M.D., Louisville, Chairman; Glenn W. Bryant, M.D., Louisville; Don E. Cloys, M.D., Richmond; Ward O. Griffen, M.D., Lexington; and L. Martin Wilson, M.D., Bowling Green.

MAKE YOUR RESERVATIONS NOW

It is important that you make your room reservations as soon as possible for the KMA Annual Meeting, September 26-28. The Hyatt Regency/Lexington will be the Headquarters Hotel; however, there are other accommodations within easy reach of the Lexington Convention Center. In making your reservations, remember the first House of Delegates meeting will be Monday, September 25.

REGISTRATION INFORMATION

A registration booth will be located in the Technical Exhibit Hall of the Lexington Convention Center throughout the Annual Meeting. The booth will be open at 8 a.m., Tuesday, Wednesday, and Thursday, September 26-28.

Please register and wear your badge at all times while attending the meetting.

Annual Meeting Special Features

SCIENTIFIC SESSIONS are scheduled for September 26, 27, and 28 at the Lexington Convention Center, Lexington. Themes of the four general sessions are "Endocrine Problems," and "Pulmonary Disease." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

TWENTY SPECIALTY GROUPS will hold meetings on the afternoons of September 26 and 28. Beginning at 1:30 p.m., the meetings will be held in the Hyatt Regency/Lexington Convention Center with the exception of the Kentucky Dermatological Society, which will meet at the Lexington Clinic. Individual programs of the specialty societies are listed in this issue. No general sessions are scheduled during the specialty group meetings and all KMA members are invited to attend any specialty meetings.

SCIENTIFIC AND TECHNICAL EXHIBITS will display new medical products, services, and techniques at the Lexington Convention Center during the 1978 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

THE KMA HOUSE OF DELEGATES will meet twice during the Annual Meeting. The first session of the House will be held at 9 a.m. Monday, September 25 in the Regency Ballroom, Hyatt Regency Hotel. The final session will be held Wednesday, September 28, at 6 p.m., in the Regency Ballroom also. Officers for the 1978-79 Associational year will be elected at the second session.

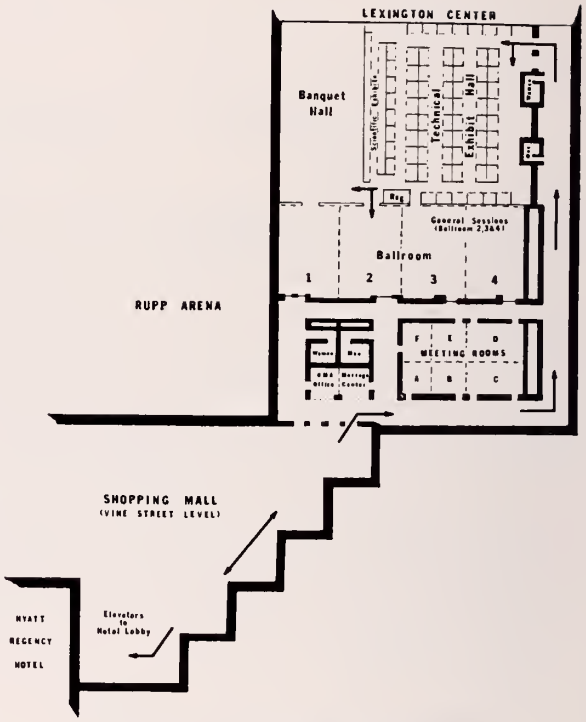
1978 Annual Meeting To Honor Past President Mathews

The 1978 Annual Meeting of the Kentucky Medical Association will be officially titled "The Joseph M. Mathews Memorial Meeting, in remembrance of the 1898 President of the Association.

Doctor Mathews

The tradition of honoring a past president of KMA and other distinguished physicians originated at the 1935 Annual Meeting.

Eugene H. Connor, M.D., Louisville, KMA Historian, has written a biography on Doctor Mathews for the Annual Meeting program booklet to be distributed during the meeting in Lexington September 26-28.



Layout of Hyatt Regency/Lexington Convention Center, Lexington, Ky.

THE PRESIDENT'S LUNCHEON will feature an address by The Honorable Julian M. Carroll, Governor of the Commonwealth of Kentucky. Held at 11:50 a.m., Wednesday, September 27, in the Banquet Hall of the Lexington Convention Center, the Luncheon also will include the presentation of KMA awards and the installation of the 1978-79 KMA President, Carl Cooper, Jr., M.D.

ALUMNI REUNIONS will be held again this year for eight classes of the University of Louisville School of Medicine. Information regarding these reunions may be obtained by contacting the chairman of the specific year listed elsewhere in this issue or may be picked up at the alumni booth at the Annual Meeting.

U OF L - UK INFORMATION BOOTH

All alumni are invited to drop by the joint U of L - UK information booth for help in locating friends and classmates and to get the latest information on the progress at the Medical School, Health Sciences Center, and University of Louisville.

1978 Annual Meeting Program Summary

Kentucky Medical Association

September 24, 25, 26, 27 and 28

Hyatt Regency Hotel/Lexington Convention Center

Lexington

SUNDAY, SEPTEMBER 24

12:30 p.m.	Luncheon Meeting, KMA Board of Trustees	Hyatt Suite, Hyatt Regency

MONDAY, SEPTEMBER 25

9:00 a.m.	First Meeting, KMA House of Delegates	Regency Ballroom, Hyatt Regency
12:30 p.m.	Luncheon, Reference Committee Chairman	Mary Todd Lincoln Room, Hyatt Regency
2:00 p.m.	Reference Committee Meetings	Meeting Rooms A,B,C,D,E and F, Lexington Convention Center
6:00 p.m.	KEMPAC Reception, Banquet and Seminar	Regency Ballroom, Hyatt Regency

TUESDAY, SEPTEMBER 26

8:00 a.m.	Registration	Exhibit Hall, Lexington Convention Center
8:50 a.m.	Opening Ceremonies	General Assembly Hall, (Ballroom) Lexington Convention Center
9:00 a.m.	First Scientific Session	General Assembly Hall, Lexington Convention Center
12:00 noon	Luncheon Meeting, Executive Committee and Reference Committee Chairman	Atlanta Room, Hyatt Regency
1:30 p.m.	Specialty Group Sessions, Convention Center (Nine Specialty Groups will meet simultaneously at this time. Their programs begin on page 396).	
5:30 p.m.	Reception Honoring Carl Cooper, Jr., M.D., and Mrs. Gordon Betts	Foyer, Regency Ballroom, Hyatt Regency

WEDNESDAY, SEPTEMBER 27

9:00 a.m.	Second Scientific Session	General Assembly Hall, Lexington Convention Center
11:50 a.m.	President's Luncheon	Banquet Hall, Lexington Convention Center
2:30 p.m.	Third Scientific Session	General Assembly Hall, Lexington Convention Center
3:00 p.m.	Board of Trustees Meeting and Dinner (5 p.m.)	Hyatt Suite, Hyatt Regency
6:00 p.m.	Second Meeting, KMA House of Delegates	Regency Ballroom, Hyatt Regency

THURSDAY, SEPTEMBER 28

9:00 a.m.	Fourth Scientific Session	General Assembly Hall, Lexington Convention Center
12:00 noon	Luncheon Meeting, Board of Trustees	Hyatt Suite, Hyatt Regency
1:30 p.m.	Specialty Group Sessions, Lexington Convention Center (Ten Specialty Groups will meet simultaneously at this time. Their programs begin on page 400).	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting Scientific and Technical Exhibits

(Full Scientific Program begins on next page)

The Kentucky Medical Association
SCIENTIFIC PROGRAM

Joseph M. Mathews Memorial Meeting
Lexington Convention Center, Lexington

TUESDAY, SEPTEMBER 26

MORNING SESSION
General Session

John P. Stewart, M.D., Frankfort
KMA President, Presiding

Theme: "Pulmonary Disease"

8:50 a.m. Opening Ceremonies

9:00 a.m. "Simplified Approach to the Assessment and Management of Acute Respiratory Failure"
Paul M. Stevens, M.D., Houston, Tex.

9:30 a.m. "General Hospital & Office Treatment of TB"
John G. Weg, M.D., Ann Arbor, Mich.

9:50 a.m. "Pros & Cons of IPPB"
James V. Maloney, M.D., Los Angeles, Calif.

10:10 a.m. "Pre and Post Operative IPPB"
Terring W. Heironimus, III, M.D., Morgantown, W. Va.

10:30 a.m. Intermission

11:00 a.m. EMERGENCY PHYSICIAN
(To Be Announced)

11:20 a.m. "Thromboembolism and its Avoidance"
James H. Dobyns, M.D., Rochester, Minn.

11:40 a.m. "Pneumococcus Immunizations"
Sarah H. Sell, M.D., Nashville, Tenn.

AFTERNOON SESSION

Ten Specialty Group Meetings

(Ten specialty groups will have simultaneous scientific programs beginning at 1:30 p.m. No general session will be held at this time.)

Kentucky Society of Anesthesiologists

Room C

1:30 p.m. "Anesthetic Management of the Diabetic"
Terring W. Heironimus, III, M.D., Morgantown, W. Va.

2:00 p.m. "History of Anesthesiology in Kentucky"
Eugene H. Conner, M.D., Louisville

2:30 p.m. Intermission to Visit Exhibits

3:00 p.m. Business Meeting

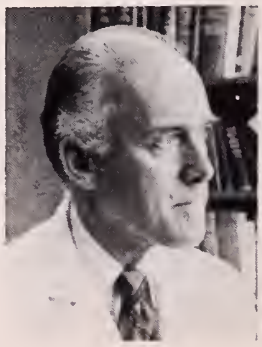
PAUL M. STEVENS, M.D.
Houston, Texas

Professor of Medicine, Chief of Pulmonary Section, Baylor College of Medicine, Houston, Texas. M.D., 1958, University of Vermont. Member, American Thoracic Society; Fellow, American College of Physicians; Received National Heart and Lung Institute Pulmonary Academic Award. Long active in aerospace medicine; has published many articles in scientific journals.

JOHN G. WEG, M.D.
Ann Arbor, Michigan

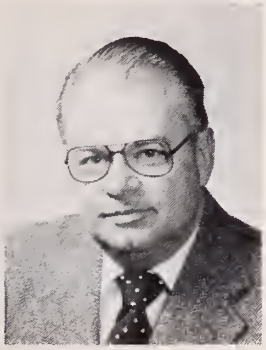
Professor of Internal Medicine, Physician-in-Charge, Pulmonary Division, University of Michigan. M.D., 1959, New York Medical College; Consultant, Pulmonary Medicine Community Based Education Project at University of Michigan. Member American Thoracic Society; Fellow, American College of Chest Physicians; Past President, Michigan Thoracic Society; Member, Editorial Board of Heart and Lung.

JAMES V. MALONEY, JR., M.D.
Los Angeles, California



Chairman, Department of Surgery, University of California Medical Center. M.D., 1947, University of Rochester School of Medicine. Member, American Board of Surgery, Board of Thoracic Surgery; Fellow, American College of Surgeons; Visiting Professor of Surgery, University of Alberta and Northwestern University; Past President, Society of University Surgeons; Special Consultant for National Institute of Health.

TERRING W. HEIRONIMUS, III, M.D.
Morgantown, West Virginia



Professor in Anesthesiology, West Virginia University Medical Center; M.D., 1955, University of Virginia. Member, American Society of Anesthesiologists, American Thoracic Society. Fellow, American College of Chest Physicians and American College of Anesthesiologists; Medical Director, Respiratory Therapy, West Virginia University; author of many articles on respiratory problems and techniques of treatment.

JAMES H. DOBYNS, M.D.
Rochester, Minnesota

Assistant Professor, Mayo Clinic/Foundation, Rochester, Minnesota. M.D., 1948, University of Indiana Medical School. Member, American College of Surgeons and American Academy of Orthopaedic Surgeons. Active in research of clinical aspects of hand and upper limb and biomechanical wrist function implant materials.

SARAH H. SELL, M.D.
Nashville, Tennessee

Medical Consultant to the Bureau of Health Services Administration for the Department of Public Health, State of Tennessee. M.D., 1948, Vanderbilt University Medical School. Diplomate, American Board of Pediatrics; former Professor of Pediatrics, Vanderbilt School of Medicine. Member, Task Force on Continuing Education of American Board of Pediatrics.

EVAN A. STEIN, M.D.
Cincinnati, Ohio

Assistant Professor of Pathology, University of Cincinnati Medical Center; Assistant Professor of Internal Medicine, University of Cincinnati Medical Center. M.D., 1974, University of Witwatersrand Medical School, Johannesburg, South Africa. Affiliated with Ontario College of Physicians and Surgeons, American Society of Clinical Chemists. Fellow, Royal College of Physicians and Surgeons of Canada; Member, South African Medical Association, American Federation for Clinical Research.

Kentucky Chapter
American College of Chest Physicians

Room 2

1:30 p.m. "Acute Respiratory Failure: The Adult Respiratory Distress Syndrome" (An update on the physiologic consequences of PEEP)
John G. Weg, M.D., Ann Arbor, Mich.

2:30 p.m. Intermission to Visit Exhibits

3:30 p.m. Roundtable discussion and rest of program to follow

Kentucky Chapter
American College of Emergency Physicians

Room B

Program To Be Announced

Kentucky Orthopaedic Society

Room D

1:30 p.m. "Supracondylar Osteotomies for Gunstock Deformities of Humerus"
H. Brooks Morgan, M.D., Lexington

1:45 p.m. Higley Nail Fixation of Unstable Intertrochanteric Fractures"
George E. Ainsworth, M.D., Madisonville

2:00 p.m. "Giant Cell Tumor Lateral Femoral Condyle Allograph Replacement"
O. James Hurt, M.D., Louisville

2:15 p.m. "The Treatment of Congenital Pseudoarthrosis of the Tibia by a Vascularized Rib Graft"
James W. Harkess, M.D. and Tse-Ming Tsai, M.D., Louisville

2:30 p.m. Intermission to Visit Exhibits

3:00 p.m. "Wrist Fractures and their Management"
James H. Dobyns, M.D., Rochester, Minn.

3:30 p.m. "Avascular Necrosis of Femoral Head"
Ralph I. Touma, M.D., Ashland

3:45 p.m. "Altering the Forces of Growth and the Mechanics in the Developing and Mature Spine"
K. D. Leatherman, M.D., Louisville

Kentucky Society of Pathologists

Room A

1:30 p.m. "The Lipoproteins Cascade and Atherosclerosis"
Evan A. Stein, M.D., Cincinnati, Ohio

2:30 p.m. Intermission to Visit Exhibits

3:00 p.m. Business Meeting

Kentucky Chapter
American Academy of Pediatrics

Assembly Hall

1:30 p.m. "Chronic Lung Diseases of Children"
Linda R. Walters, M.D., Lexington

2:00 p.m. "Recent Advances in the Conquest of Bacterial Meningitis"
Sarah H. Sell, M.D., Nashville, Tenn.

2:45 p.m. Intermission to Visit Exhibits

3:15 p.m. "Viral Infections of the Central Nervous System"
H. Garrett Adams, M.D., Louisville

3:45 p.m. Question and Answer Session

4:00 p.m. Business Meeting

Kentucky Society for Plastic and Reconstructive Surgery

Room F

1:30 p.m. "Breast Reconstruction Following Radical Mastectomy"
Henry W. Neale, M.D., Cincinnati, Ohio

1:45 p.m. "Pros and Cons of Breast Reconstruction Following Radical Mastectomy"
Edward A. Luce, M.D., Lexington

2:00 p.m. "Subcutaneous Mastectomy"
Nicholas G. Georgiade, D.D.S., M.D., Durham, N.C.

2:20 p.m. Discussion

2:30 p.m. "Technical Improvements in Inflatable Implants"
Raleigh R. Archer, M.D., Lexington

2:45 p.m. "Surgical Correction of The Long Face Syndrome"
Gerald D. Verdi, D.D.S., M.D., Louisville

3:00 p.m. "Cancer of the Lip—Surgical Aspects"
Phillip K. Blevins, M.D., Lexington

3:15 p.m. Discussion/Break to Visit Exhibits

3:30 p.m. "Multiple Basal Cell Nevus Syndrome"
Carl Wayne Cruse, M.D., Lexington

3:45 p.m. "Repair of Primary and Secondary Facial Defects with Free Flaps"
Jerry C. Lingle, M.D., Louisville

4:00 p.m. Discussion

4:15 p.m. Annual Business Meeting

Kentucky Chapter American College of Surgeons

Room I

1:30 p.m. "Extended Transthoracic Devascularization for Treatment of Bleeding Esophageal Varices"
Norman C. Estes, M.D., Lexington

1:45 p.m. "The Doctor Plethora"
James V. Maloney, Jr., M.D., Los Angeles, Calif.

2:30 p.m. Intermission to Visit Exhibits

3:00 p.m. "Conservative Surgery of the Larynx—Epiglottic Reconstruction"
Thomas Kennedy, M.D., Louisville

3:15 p.m. "Morbid Implications of Amputation Above the Knee"
Charles Huston, M.D., Lexington
Brack Bivins, M.D., Lexington

3:30 p.m. "The Role of Endoscopy in the Management of Esophagitis"
Martin Max, M.D., Louisville
Carl O. Knutson, M.D., Louisville

3:45 p.m. "Management of Laryngeal Cancer"
Gary Griffith, M.D., Lexington
Edward Luce, M.D., Lexington

4:00 p.m. "Abdominal Aortic Aneurysm—Clinical Variations and Therapy"
J. L. Hamman, M.D., Madisonville

Kentucky Urological Association

Room E

1:30 p.m. "Vasectomy—Technique, Effects and Reversibility"
Joseph E. Davis, M.D., New York, N.Y.

JOSEPH E. DAVIS, M.D.
New York, New York

Professor and Chairman, Department of Urology, New York Medical College. M.D., 1953, New York Medical College. Member, American College of Surgeons, American Fertility Society, American Urological Association and International Urological Association. President, Association for Voluntary Sterilization; Chairman, Education and Curriculum Committee, New York Medical College. Author of many papers relating to male fertility and urology.

LAURENCE S. FARER, M.D.
Atlanta, Georgia

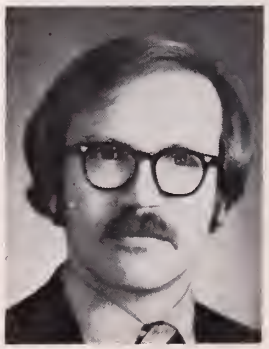
Director, Tuberculosis Control Division, Center for Disease Control, Atlanta. M.D., 1961, New York University School of Medicine, M.P.H., 1970, Harvard University School of Public Health. Former World Health Organization Epidemiologist in India, Pan American Health Organization consultant in Venezuela, advisor to Peace Corps in Korea. Diplomate of American Board of Internal Medicine, American Thoracic Society, and International Union Against Tuberculosis.

NICHOLAS G. GEORGIADE, M.D., D.D.S.
Durham, North Carolina

Professor and Chairman, Division of Plastic, Maxillofacial and Oral Surgery, Duke University School of Medicine; D.D.S., 1944, Columbia University School of Dental and Oral Surgery; Member and Past President, American Society of Maxillofacial Surgeons. Fellow, American College of Surgeons; former International Editor, Cleft Palate Journal; Past President, American Association of Plastic Surgeons.

CARL O. KNUTSON, M.D.
Louisville, Kentucky

Associate Professor of Surgery, University of Louisville. M.D., 1965, University of Michigan. Diplomate, American Board of Surgery. Chief, Surgical Endoscopy, UL. Fellow, American College of Surgeons. Member, Association for Academic Surgeons, Society of Head and Neck Surgeons, American Association for Cancer Education. Co-investigator in 1973, American Cancer Society Breast Cancer Screening Project.



BRUCE W. KARRH, M.D.
Wilmington, Delaware

Medical Director, E.I. duPont de Nemours & Company Medical Division, Wilmington, Delaware. M.D., 1962, Medical College of Alabama; Graduate U.S. Air Force School of Aerospace Medicine; long active in environmental medicine research.

GEORGE L. BLACKBURN, M.D., Ph.D.
Boston, Massachusetts

Associate Professor of Surgery, Harvard Medical School. M.D., 1965, University of Kansas. Chief, Nutrition/Metabolic Laboratory, New England Deaconess Hospital. Member, Cancer Research Institute, New England Deaconess Hospital; New York Academy of Science; American College of Surgeons; National Research Council; Food and Nutrition Board; American Federation for Clinical Research; Society of Academic Surgeons. Former NIH Ph.D. Trainee in Nutritional Biochemistry, Massachusetts Institute of Technology.

J. STUART SOELDNER, M.D.
Boston, Massachusetts

Associate Professor of Medicine, Peter Bent Brigham Hospital, Harvard Medical School, Boston. Associate Director, E.P. Joslin Research Laboratory, Boston; M.D., 1959, Dalhousie Medical School, Halifax, Nova Scotia, Canada. President, New England Affiliate of the American Diabetes Association; Member, Endocrine Society, American Physiological Society, American Federation for Clinical Research, American Society for Clinical Investigation. Received 1973 Scientific Award from Juvenile Diabetes Foundation.

JOHN W. HOLLIFIELD, M.D.
Nashville, Tennessee

Assistant Professor of Medicine, Division of Endocrinology, Vanderbilt University School of Medicine, Nashville. M.D., 1967, University of North Carolina Medical School. Clinical Director, Specialized Center of Research in Hypertension, Vanderbilt University School of Medicine. Member of American Federation of Clinical Research and The Endocrine Society.

2:30 p.m. Intermission to Visit Exhibits
3:00 p.m. Pyelogram Hour
3:30 p.m. Business Meeting

WEDNESDAY, SEPTEMBER 27

MORNING SESSION

General Session

Robert S. Howell, M.D., Louisville
KMA Vice-President, Presiding

9:00 a.m. "Lipids, Current Profiles and Analysis"
Evan A. Stein, M.D., Cincinnati, Ohio

9:20 a.m. "A Rational Approach to the Treatment of Cancer of the Prostate"
Joseph E. Davis, M.D., New York, N.Y.

9:40 a.m. "Craniofacial Birth Defects and Their Surgical Correction"
Nicholas G. Georgiade, M.D., Durham, N.C.

10:00 a.m. Intermission

10:30 a.m. "Colonoscopy"
Carl O. Knutson, M.D., Louisville

10:50 a.m. "Concern Caused by Occupational Factors: A Perspective"
Bruce W. Karrh, M.D., Wilmington, Del.

11:10 a.m. "Role of the Physician in Obesity Treatment—Use of Rapid Weight Loss Supplemental Fasting Techniques"
George L. Blackburn, M.D., Boston, Mass.

Lunch

PRESIDENT'S LUNCHEON

Banquet Hall, Lexington Convention Center
11:50 a.m.

John P. Stewart, M.D., Frankfort
KMA President, Presiding

Invocation

Recognition

Awards Presentation
Fred C. Rainey, M.D., Elizabethtown
Chairman, KMA Awards Committee

Luncheon Speaker
The Honorable Julian M. Carroll
Governor of the Commonwealth of Kentucky

Installation of the New KMA President

WEDNESDAY, SEPTEMBER 27

AFTERNOON SESSION

General Session

Richard F. Hench, M.D., Lexington
Chairman, KMA Scientific Program Committee, Presiding

Theme: "Endocrine Problems"

2:30 p.m. "Future Prospects for a Miniature Implantable Artificial Beta Cell"
J. Stuart Soeldner, M.D., Boston, Mass.

3:00 p.m. "Thyroid Function Studies"
John W. Hollifield, M.D., Nashville, Tenn.

3:20 p.m. Intermission to Visit Exhibits

3:50 p.m. "The Importance of Cardiovascular and Renal Prostaglandins"
Michael J. Dunn, M.D., Cleveland, Ohio

4:20 p.m. "Present Status of Estrogen Therapy"
Arthur L. Haskins, M.D., Baltimore, Md.

THURSDAY, SEPTEMBER 28

MORNING SESSION

General Session

Harold L. Bushey, M.D., Barbourville
Vice-Chairman, KMA Board of Trustees, Presiding

9:00 a.m. "Superficial Temporal Artery Transplantation"
(speaker to be announced)

9:20 a.m. "Scar Camouflage Following Facial Injuries"
M. Eugene Tardy, Jr., M.D., Chicago, Ill.

9:40 a.m. "The Rational Use of Systemic Corticosteroids in Clinical Practice"
Robert Fine, M.D., Decatur, Ga.

10:00 a.m. Intermission to Visit Exhibits

10:30 a.m. "Medical Aspects of Marijuana Use"
Donald W. Goodwin, M.D., Kansas City, Kan.

10:50 a.m. "Treadmill Exercise Testing"
Gerald F. Fletcher, M.D., Atlanta, Ga.

11:10 a.m. "Clinical Use of Theophyllin Including Blood Levels"
Phillip L. Lieberman, M.D., Memphis, Tenn.

11:30 a.m. "The Role of Public Health in the Control of TB"
Laurence S. Farer, M.D., Atlanta, Ga.

Lunch

AFTERNOON SESSION

Ten Specialty Group Meetings

(Simultaneous scientific programs of ten specialty groups will be held at 1:30 p.m. All KMA members are invited and no general sessions will be held this afternoon)

Kentucky Dermatological Society

Lexington Clinic

1:30 p.m. Case Presentations

2:30 p.m. Intermission to Visit Exhibits

3:00 p.m. Discussion of cases by members of the Kentucky Dermatological Society and Doctor Robert Fine

4:45 p.m. Annual Business Meeting

Kentucky Society of Allergy and Clinical Immunology

Room F

1:30 p.m. "Anaphylactoid Reactions to I.V. Administration of Radiographic Contrast Material"
Phillip L. Lieberman, M.D., Memphis, Tenn.

2:00 p.m. "A Rational Approach to Theophylline Therapy in Children"
Stephen J. Pollard, M.D., Louisville

2:30 p.m. Intermission to Visit Exhibits

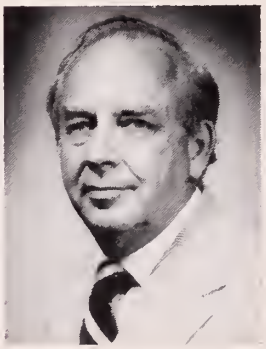
3:00 p.m. "Non-Compliance and Outpatient Treatment Failures in Asthmatic Children"
James L. Sublett, M.D., Louisville

3:30 p.m. "T-Cell Sub Populations"
Ronald Moyer, M.D., Louisville

MICHAEL J. DUNN, M.D.
Cleveland, Ohio

Hanna Payne Professor of Experimental Medicine and Director, Division of Nephrology, Case Western Reserve University, College of Medicine, Cleveland, Ohio. M.D., 1962, Marquette Medical School; Member, American Society of Nephrology and Johns Hopkins Medical and Surgical Society; Fellow, American College of Physicians; 1969-1975 Markle Scholar in Academic Medicine.

ARTHUR L. HASKINS, M.D.
Baltimore, Maryland

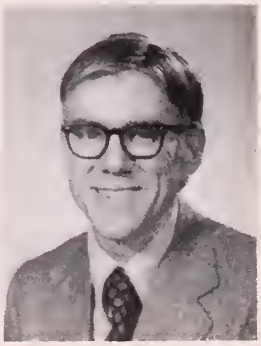


Professor and Head, Obstetrics and Gynecology, University of Maryland School of Medicine. M.D., 1943, University of Rochester School of Medicine. Member, American Association of Obstetricians and Gynecologists, American College of Surgeons, American Gynecological Society; Past President, Association of Professors of Gynecology and Obstetrics.

M. EUGENE TARDY, JR., M.D.
Chicago, Illinois

Private practice, Chicago. M.D., 1960, Indiana University Medical School, Indianapolis; Diplomate, American Board of Otolargyngology; Fellow, American College of Surgeons; Member, Aerospace Medical Convention, Council on Medical Television; Associate Professor of Otolaryngology, University of Illinois. Involved in active research relative to otolaryngology. Author of three textbooks on plastic and reconstructive surgery.

ROBERT M. FINE, M.D.
Atlanta, Georgia



Clinical Associate Professor of Medicine, Emory University School of Medicine, Atlanta. M.D., 1955, Tulane University School of Medicine. Member American Academy of Allergists, American College of Allergists, Society for Investigative Dermatology. Advisor, National Psoriasis Foundation and Cosmetic Ingredient Review. Author of numerous scientific papers on dermatology.

DONALD W. GOODWIN, M.D.
Kansas City, Kansas

Professor of Psychiatry and Chairman of the Department of Psychiatry, University of Kansas Medical Center, Kansas City, Kansas. M.D., 1964, Kansas University School of Medicine. Visiting Professor, Menninger School of Psychiatry, Topeka, Kansas; Publications Consultant for American Journal of Psychiatry and the Journal of the American Medical Association; Chairman, Research Committee, American Medical Society on Alcoholism; Former Director, Washington University Addiction Research Center; Active in research on drug and alcohol abuse.

GERALD F. FLETCHER, M.D.
Atlanta, Georgia

Professor of Medicine, Emory University School of Medicine, Atlanta; M.D., 1961, Emory University. Fellow, American College of Cardiology, Council of Clinical Cardiology, American College of Chest Physicians. Member, Subcommittee on Rehabilitation of American Heart Association, American Heart Association Target Activity Group for Developing Standards for Cardiovascular Exercise Treatment Programs. Diplomate, American Board of Internal Medicine.

PHILLIP LIEBERMAN, M.D.
Memphis, Tennessee

Associate Professor, Chief, Section of Allergy-Immunology, University of Tennessee. M.D., 1965, University of Tennessee School of Medicine. Diplomate, American Board of Internal Medicine; Fellow, American College of Allergists, American College of Physicians, American Academy of Allergy; Member American Association of Immunology; Visiting Professor in numerous medical symposia since 1971. Author of textbooks on allergy and immunology.

Kentucky ENT Society
Room E

1:30 p.m. "Contemporary Approaches to Rhinoplasty"
M. Eugene Tardy, Jr., M.D.F.A.C.S., Chicago, Ill.
2:30 p.m. Intermission to Visit Exhibits
3:00 p.m. Panel Discussion (topic to be announced)
3:30 p.m. Business Meeting

Kentucky Academy of Eye Physicians and Surgeons
Ballroom East—Hyatt Hotel

1:30 p.m. "New Methods in Diagnosis and Treatment of Glaucoma"
Albert Potts, M.D., Louisville
2:00 p.m. "Uses and Abuses of Clinical Visual Electrophysiological Testing"
Theodore Lawwill, M.D., Louisville
2:30 p.m. Intermission to Visit Exhibits
3:00 p.m. "Pigmentary Retinal Degenerations"
Donald Bergsma, M.D., Lexington
3:30 p.m. "Vitamin A Receptor Proteins"
Donald Bergsma, M.D., Lexington
4:00 p.m. Business Meeting

Kentucky Chapter American Academy of Family Physicians
Room 2

1:30 p.m. "Recognition of Secondary Hypertension"
(A) Reno Vascular
(B) Minerald Corticoid
John W. Hollifield, M.D., Nashville, Tenn.
2:45 p.m. Intermission to Visit Exhibits
3:15 p.m. "Evaluation of the Solitary Thyroid Nodule"
John W. Hollifield, M.D., Nashville, Tenn.

Kentucky Neurosurgical Society
Room A
(To Be Announced)

Kentucky Occupational Medical Association
Room C
(To Be Announced)

Kentucky Chapter American College Of Physicians
Room 1

1:30 p.m. "Uses and Abuses of Cimitidine in the Management of Peptic Ulcer Disease"
John Banwell, M.D., Lexington, Ky.
2:00 p.m. "Prescribed Exercise for the Medical Patient"
Gerald F. Fletcher, M.D., Atlanta, Ga.
2:30 p.m. Intermission to Visit Exhibits
3:00 p.m. "Metronidazole in the Treatment of Anaerobic Infection"
Martin J. Raff, M.D., Louisville
3:30 p.m. "Treatment of Mild Hypertension"
Gordon Guthrie, M.D., Lexington, Ky.

Kentucky OB-GYN Society
Assembly Hall

1:30 p.m. "Estrogens Forever"
Arthur L. Haskins, M.D., Baltimore, Md.
2:15 p.m. "Micro-Surgical Training and Techniques in Obstetrics and Gynecology"
Marvin A. Yussman, M.D., Louisville
3:00 p.m. Intermission to Visit Exhibits
3:30 p.m. "Adjunctive and Alternative Therapy of the Menopause Other Than Estrogens"
Emery A. Wilson, M.D., Lexington

Kentucky Psychiatric Association
Room D

1:30 p.m. "The New Nomenclature: DSM3"
Donald W. Goodwin, M.D., Kansas City, Kan.
2:30 p.m. Discussion
3:00 p.m. Intermission to Visit Exhibits
3:30 p.m. Business Session

Kentucky Association of Public Health Physicians
Room B

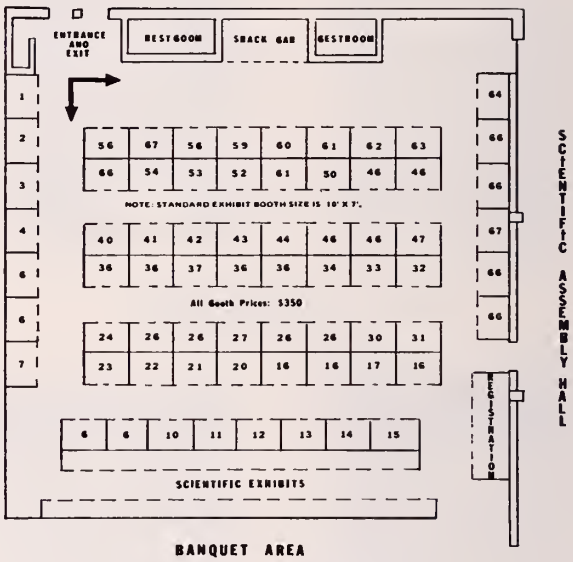
1:30 p.m. "Questions and Answers about Tuberculosis"
Laurence S. Farer, M.D., Atlanta, Ga.

Latest Research Advances in Products and Services Offered by 1978 Technical Exhibits

The technical exhibits at the 1978 KMA Annual Meeting will feature the latest developments in medical techniques and information. Located in the Hyatt Regency/ Lexington Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

Prepared carefully and skillfully to appeal to you, the physician, the exhibits are especially geared to your special interests as a practitioner. Medical representatives and other exhibitors will be on hand to discuss personally their products and services with you. Both you and your patients should benefit from the information that can be gained from a visit to the Technical Exhibits.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this excellent opportunity provided by the exhibits.



Floor Plan of Technical Exhibits

1978 TECHNICAL EXHIBITORS

Abbott Laboratories (40)
Acme Visible Records, Inc. (29)
Armour Pharmaceutical Co. (37)
Arnar-Stone Laboratories, Inc. (68)

Blue Cross and Blue Shield of Kentucky (1)
Bristol Laboratories (36)
Burroughs Wellcome Co. (60)

The Central Pharmacal Company (53)
Cooper Laboratories, Inc. (16)

Dictaphone Corporation (4)
Division for Disability Determinations (12)
Dolbey and Company (42)
Dow Chemical Co. (52)

Encyclopaedia Britannica (24)

Fisons Corporation (43)
Flint Laboratories (45)

Geigy Pharmaceuticals (67)
General Medical (47)
Gerber Products Co. (33)
Grogan's Surgical Supply (28)
Guild of Prescription Opticians of Kentucky (35)

John Hancock Life Insurance Co. (65)

Hoechst-Roussel Pharmaceuticals, Inc. (54)

International Clinical Laboratories of Kentucky (51)
International Medical Electronics, Ltd. (27)
Ives Laboratories, Inc. (23)

KMA Insurance Agency, Inc. (20)
Kremers-Urban Company (13)

Lederle Laboratories (57)
A. P. Lee Agency, Inc. (62)
Eli Lilly and Company (64)

McNeil Laboratories (39)
Main, Inc. (26)
Malkin Instrument Co., Inc. (69)
Mead Johnson Nutritional Division (49)
Mead Johnson Pharmaceuticals (59)
Medec Management, Inc. (38)
The Medical Protective Company (2)
Merck Sharp & Dohme (21)
Merrill Lynch, Pierce, Fenner & Smith, Inc. (44)
Metropolitan - Medicare Office (5)
Meyer Laboratories, Inc. (6)
Mitchell Orthopedic Supply (22)

NCR Corporation (11)

Ortho Pharmaceutical Corporation (56)

Pathology and Cytology Laboratories, Inc. (34)

Pfizer Labs (61)

William P. Poythress & Co., Inc. (55)

Ransdell Surgical, Inc. (17)
R. J. Reynolds Tobacco Co. (8)
Richards Manufacturing Company, Inc. (25)
A. H. Robins Company (31)
Roche Laboratories (48)
William H. Rorer, Inc. (14)
Ross Laboratories (15)

Sandoz Pharmaceuticals (66)
W. B. Saunders Company (50)
Clayton L. Scroggins Associates, Inc. (7)
Searle Laboratories (63)
E. R. Squibb & Sons, Inc. (58)
Stuart Pharmaceuticals (32)
Syntex Laboratories, Inc. (41)
Systemedics/A.M.S. (18)

Tutag Pharmaceuticals (10)

USAF Recruiting (9)
U.S. Army Medical Department Personnel Procurement Division (19)

Warren-Teed Laboratories, Inc. (46)
Wyeth Laboratories (30)

Zimmer USA, Inc. (3)

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E.W. Ernst, Jr., Administrator **Ray D. Jones, Associate**

EDITORIAL

Hail and Reign

Congratulations to Hoyt D. Gardner, M.D., upon being voted President-Elect of the AMA at the St. Louis Convention last month.

With this honor, Hoyt Gardner will be the eighth Kentuckian to serve as president of our national political arm, the others being Doctors Henry Miller, David W. Yandell, Joseph McDowell Mathews, Louis S. McMurtry, Irvin Abell, E. L. Henderson, and Fred Rankin.

Hoyt Gardner, a general surgeon from Louisville, is a 1950 graduate from the University of Louisville School of Medicine. He brings with him a long and illustrious list of qualifications and accomplishments at the local, state, and national level. Just prior to his election as President, he served two terms as AMA trustee.

Hoyt is richly deserving of this prize. He bestows honor upon himself, his family, his state, and his alma mater. Congratulations, Doctor Gardner. With you in the chair and gavel at hand, I feel "safe" for one more year during your reign.

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ASSOCIATIONAL NEWS

1978 U. S. SENATE CANDIDATES TO SPEAK AT KEMPAC SEMINAR

Kentucky's two candidates for the U. S. Senate will be the featured speakers at the Sixteenth Annual KEMPAC Seminar and Banquet to be held on Monday, September 25.

Wally O. Montgomery, M.D., Paducah, KEMPAC Chairman, has announced that Walter "Dee" Huddleston (D-Elizabethtown) and Louie Guenther, Jr. (R-Northfield) will discuss "Campaign '78" at the Seminar.

The Seminar will be held in the Ballroom of the Hyatt Regency Lexington, starting with a reception at 6:00 p.m. with dinner and the program to follow.

The KEMPAC Board of Directors invite you to attend and urge you to make plans now. You can purchase tickets from the Director in your area or clip the coupon below and mail with your check to KEMPAC, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205. The price of the ticket is $15.00 each.

— — — — — — — — — — — — — — — — — — — —

Name _____

Address _____

Please send _____ tickets (8 spaces at a table). Enclosed is my check in the amount of $_____.
(Reservations must be in by Monday, September 18.)

Dr. Wally O. Montgomery, Paducah, KEMPAC Chairman (left), accepts the AMPAC Leadership Award from Dr. Rex Kenyon, AMPAC Chairman, at the AMA Annual Convention in St. Louis. The award was presented to Kentucky for having the leadership of KMA and KEMPAC, Sustaining members of KEMPAC, and Sustaining members of AMPAC. This is the second year Kentucky has received the award.

COSLA COMMITTEE MEETS

The Committee on State Legislative Activities (COSLA) met July 19 at Headquarters to review and evaluate the activities and results of the 1978 Kentucky General Assembly (KGA). The results were considered favorable for KMA.

The committee's other actions:

- Considered possible legislation for the 1980 KGA that may include a number of bills on issues that would dilute physicians' authority in medical care and diminish their traditional role.
- Discussed potential KMA-sponsored legislation.
- Discussed plans to work with all groups in the federation to determine legislative priorities.
- Recommended that anyone with a legislative concern contact COSLA at KMA.

Digest of Proceedings Board of Trustees June 1, 1978

The KMA Board of Trustees met on June 1, 1978, preceding a called meeting of the KMA Insurance Agency, Inc. Board of Directors.

Doctor Stewart reported in detail on KMA activities to include that he had addressed 11 of 15 KMA Districts recently where much discussion was held on the Kentucky Medical Insurance Company.

He indicated his desire for KMA to begin preparing for the 1980 Kentucky General Assembly. It was reported that KMA is actively participating in the Voluntary Effort Cost Containment in Kentucky and the sharing of the expenses for this activity was authorized.

Reports were submitted by the Membership and Placement Services Committee and the Advisory Committee to Blue Cross and Blue Shield. Authorization was given for co-sponsorship of the 1979 Medical Aspects of Sports Seminar with the University of Kentucky CME Department. The KMA Continuing Medical Education Committee received permission to bring representatives from the Utah Medical Education Foundation to Kentucky to discuss CME Programs.

A lengthy session was held with the president of the Kentucky Chapter, American College of Radiology, who discussed with the Board: 1) some current radiology regulations; 2) S. B. 94 relating to the inspection of X-ray equipment; and 3) the matter of separate billing by hospital-based physicians.

Other actions of the Board include:

- Endorsed a seminar on the treatment of rape victims to be held statewide.

✓ Endorsed a study to determine the appropriate role of barbiturates and other sedative-hypnotics in current medical practice.

✓ Received a report on the status of the Patients' Compensation Fund.

✓ Turned down an offer from HEW for KMA to be a listholder on HEW's Second Consultation on Elective Surgery Plan.

✓ Received a full report on recent activities concerning the formation of the Kentucky Medical Insurance Company, following which a Search Committee was appointed to seek a president of the company. An Underwriting Committee was also appointed.

It was noted that the next meeting of the Board was its regularly scheduled session on August 9-10, 1978.

Members in the news

NEW MEMBERS

BARREN
Leticia Alojipan Bravo, M.D., Glasgow

BOYD
Michael L. Clark, M.D., Ashland
Douglas E. McKinney, M.D., Ashland
Mirudula Shah, M.D., Ashland

BOYLE
Richard Jackson, M.D., Danville

BUTLER
Hsing-Ying Hsieh, M.D., Morgantown

FAYETTE
James K. Cooper, M.D., Lexington
Adrian A. Fulmer, M.D., Lexington
Sidney F. Hopkins, M.D., Lexington
Leslie D. Johnson, M.D., Frankfort
Fred D. Stahmann, M.D., Lexington

FLOYD
Narong Chalothorn, M.D., Prestonsburg

GRAVES
Jay M. Walshon, M.D., Mayfield

HARDIN
Robert K. Myers, M.D., Elizabethtown
Henri Claude Richard, M.D., Radcliff

HARRISON
Emanuel D. Anama, M.D., Cynthiana

HENDERSON
Emmanuel Macaraeg, M.D., Henderson
Gerald F. Meier, M.D., Madisonville
James H. Lambert, M.D., Madisonville

HOPKINS
Ronald E. Taylor, M.D., Madisonville

JEFFERSON
Eric Hilgeford, M.D., Louisville
John G. Hubbard, M.D., Louisville
John B. Larson, Jr., M.D., Louisville
Joseph B. Leroy, M.D., Louisville
Larry Edward Martin, M.D., Louisville
Lucy G. Pike, M.D., Anchorage
David L. Speer, M.D., Campbellsburg

LAWRENCE
Md Khaja N. Ahmed, M.D., Louisa
Ahmed Ali, M.D., Louisa

MADISON
John Gallanis, M.D., Richmond
Raymond Jackson, M.D., Richmond
Richard Wiesemann, M.D., Richmond

McCRACKEN
Sally H. Chaney, M.D., Paducah
David De Villez, M.D., Paducah
James E. Phillips, M.D., Paducah

OLDHAM
James A. Halikas, M.D., Goshen

PIKE
David M. De la Rosa, M.D., Pikeville

SHELBY
Priscilla De Dios, M.D., Shelbyville

HONORS BESTOWED

Kay Kirkpatrick, Class of 1980, University of Louisville School of Medicine, was elected Vice-Chairperson for the Student Business Section of the AMA for the coming year.

Arthur H. Keeney, M.D., dean and professor of ophthalmology at the University of Louisville School of Medicine, has been appointed to the Board of Trustees of the James Graham Brown Foundation, Inc. of Louisville.

In Memoriam

James T. Linville, M.D.
Louisville

James T. Linville, M.D., died on July 2 at the age of 53. A 1958 graduate of the University of Louisville School of Medicine, Doctor Linville had been in private practice as a family physician since 1958. He was a member of the Kentucky and American medical associations.

George H. Widener, Jr., M.D.
Paducah

George Hoy Widener, Jr., M.D. died in late June in Paducah. An ophthalmologist, Doctor Widener was a 1947 graduate of the University of Louisville School of Medicine, and did post graduate training at Tulane University Hospital and the New Orleans, La., Eye, Ear, Nose and Throat Hospital. Doctor Widener was a fellow of the American College of Surgeons, a member of the American Academy of Ophthalmology, and a diplomate of the American Board of Ophthalmology.

O. D. (Sam) Maxey, M.D.
Paducah

O. D. (Sam) Maxey, a pioneer in the practice of urology in Paducah, died this month at the age of 63. Doctor Maxey was a graduate of Baylor University and served as a surgeon for the British Royal Air Force. Before moving to Paducah, Doctor Maxey practiced in Dallas, Texas, New York City, and Louisville, Kentucky. He was a member of Beta Kappa Psi fraternity, and was active in the Lions Club of Paducah.

Trustees' Report

SECOND TRUSTEE DISTRICT
R. J. Phillips, Jr., M.D., Owensboro

The Second Trustee District meeting, May 23, at Owensboro featured discussion of the KMA insurance agency, the liability policy now available to members, and sale of stock in the KMA company. Doug Freeman, manager of the KMA Insurance Agency, explained some provisions of the policy that have not been available from other sources. This summer when the prospectus is available, stock will be issued.

Doctor Stewart reviewed some highlights of the recent legislative session, and discussed KMA interest and action in future legislation. Bob Cox reported on progress of Doctor Gardner's candidacy for president of the AMA. Doctor Don Neel expressed some of the objectives of KEMPAC, and the effort needed in the imminent congressional campaigns. The Daviess County Medical Society will meet in September to consider issues of the annual meeting in Lexington Sept. 25-28.

Take This Issue Home To Your Wife

You are urged to take this issue home for your wife to read. Many activities planned during the Annual Meeting will be of interest to her.

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

JULY

6	Membership and Placement Services Committee, Louisville
10	Journal Editors, Louisville
13	Board of Medical Licensure
19	State legislative Activities Committee, Louisville KEMPAC Board, Louisville Kentucky Pharmacy Council, Frankfort

AUGUST

9-10	Board of Trustees, Louisville
15	Journal Editors, Louisville
16	Judicial Council, Louisville

SEPTEMBER

7	Nominating Committee, Louisville
13	Technical Advisory Council for Medical Assistance (Title XIX), Louisville
21-23	State Medical Journal Advertising Bureau Annual Conference
24-28	KMA ANNUAL MEETING

MGA Schedules Golf Tournament for September 25

APPLICATION

MGA

The Kentucky Medical Golf Association will hold its annual fall tournament in connection with the KMA Annual Meeting in Lexington on Monday, September 25, at the Greenbrier Golf and Country Club in Lexington (the Greenbrier is on Winchester Road about three miles off the Beltline).

Assessment for the tournament is $25 which includes green fees, carts, and prizes, with prizes being awarded in both gross and net categories.

Physicians may tee off at any time on that date and make up their own game, find one at the club, or call the pro shop in advance. Any physician interested in playing in the fall tournament should complete the following form:

To: Kentucky Medical Golf Association
John E. Myers, Jr., M.D.
2370 Nicholasville Road
Lexington, KY 40503

Gentlemen:

Enclosed is my check in the amount of $25 to cover assessment for the 1978 Golf Tournament. (Make check payable to Kentucky Medical Golf Association.)

Name _____ M.D.

Address _____
Zip Code

Club Affiliation _____

Current Handicap _____

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Carolina, Puerto Rico 00630

HOSPITAL COST CONTAINMENT

A much watered down version of HR 6575, the Hospital Cost Containment bill, was voted in July by the House Committee on Interstate and Foreign Commerce. By a one vote margin, the bill was accepted without an original 9% cap on hospital costs that was strongly suported by the Administration. The bill was reported from the Sub Committee on Health, chaired by Florida Representative Paul Rogers, a major proponent of the mandatory federal limit. Kentucky's 5th Congressional Representative, Tim Lee Carter, M.D., figured heavily in discussion of the bill, and won a decisive vote for the weakened legislative bill over more restrictive versions. The AMA Washington office reported adoption of the weakened bill a major victory for the Voluntary Effort to control costs, and for the private sector.

A similar bill is before the House Ways & Means Committee, which has delayed consideration of it until after the Commerce Commission has acted. It has been predicted that the issue has died for this session of Congress because of the Commerce Commission action.

New Interprofessional Code For Fayette County

The Fayette County Medical Society, in conjunction with the Fayette County Bar Association, has adopted a new Interprofessional Code. Those interested in receiving a copy of this report may contact Carolyn Larson, Executive Director, Fayette County Medical Society, 731 S. Limestone, Lexington, Kentucky 40508.

MESSAGE CENTER
606-233-4111

You may be reached at this number during the KMA Annual Meeting in Lexington, September 26-28. It is a central number through which all messages will be processed.

MANUSCRIPT INFORMATION

Manuscripts will be accepted for consideration with the understanding that they are original and are contributed solely to The Journal. They should be submitted in duplicate, typed with double spacing, and should usually not exceed 2,000 words in length.

A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should contain: 1) a brief statement of the paper's purpose, 2) the approach used, 3) the material studied, and 4) the results obtained. The synopsis should be able to stand alone and not merely duplicate the conclusions.

References should be cited consecutively in the text and should contain, in order, the author, title of article, source, volume, inclusive page numbers, year. Journal abbreviations should conform to the Index Medicus. The Journal of KMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein. The editors may use up to six different illustrations with the essayist bearing the cost of all over three one-column halftones.

Arrangements for reprints of an article are made with the printer and order forms are sent to all authors at the time of publication. When revisions and alterations not on the original copy are made by the authors on the galley proofs, a charge will be made to the authors.

Scientific articles should be mailed to The Journal of the Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

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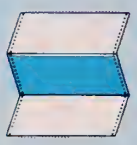

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Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

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Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
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Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

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Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sultate 5,000 units; zinc bacitracin 400 units; neomycin sultate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) toil packets.

WARNING: Because of the potential hazard ot nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption ot neomycin is possible. In burns where more than 20 percent ot the body surface is affected, especially it the patient has impaired renal tunction or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product it they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

September 1978
Volume 76
Number 9

Meetings, Committee Assignments Listed
For 1978 KMA Annual Meeting
September 25-28, Lexington

MDS

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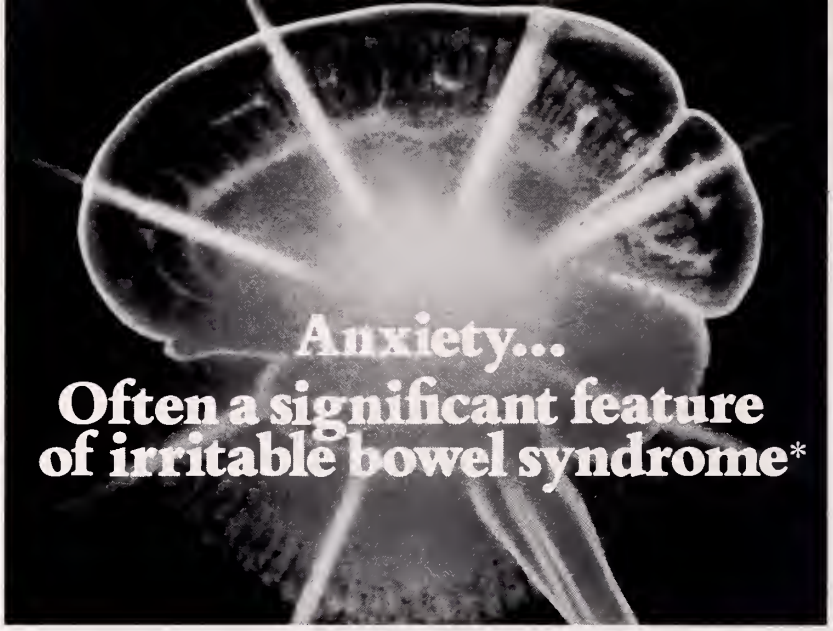

Anxiety...
Often a significant feature of irritable bowel syndrome*

The action of Librium®
(chlordiazepoxide HCl)

A significant advantage of adjunctive
Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE Roche Products Inc.
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POSTGRADUATE OPPORTUNITIES

IN KENTUCKY

SEPTEMBER

21-23 "Gynecologic Surgery," University of Louisville Department of Ob/Gyn, Louisville

24-28 KMA Annual Meeting, Hyatt Regency/Lexington Convention Center, Lexington

OCTOBER

4-6 "Topics in Medical Oncology" Symposium, Highlands Baptist Hospital. Contact Pat Strait, Coordinator, 810 Barrett Ave., Louisville, Ky. (502) 583-4841.

7 Renal Failure—Pathophysiology and Management,** University of Louisville School of Medicine

14 Kentucky Chapter, American College of Physicians Regional Meeting, Louisville

18 John Walker Moore Lecture, Health Sciences Center, Louisville

25-26 Hypertension—1978, Galt House, Louisville

NOVEMBER

2 Medical Examination in Cases of Alleged Rape** University of Louisville School of Medicine

11-12 AMA Regional CME Meeting**, Louisville

13-17 Microsurgery for Gynecologists**, University of Louisville School of Medicine

15-16 "Allergy and Immunology Symposium"**, University of Louisville School of Medicine

***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

TWELFTH ANNUAL NEWBORN SYMPOSIUM

The Department of Pediatrics, University of Louisville School of Medicine, presents its Twelfth Annual Newborn Symposium, November 9-10, 1978, at the Health Sciences Center Auditorium, Abraham Flexner Way, Louisville. Participants are Doctors A. Leland Albright, J. Alex Haller, Joan E. Hodgman, L. Stanley James, Waldo E. Nelson, Sydney Segal, and Al Zipursky. For information, contact Dr. Billy F. Andrews, U of L School of Medicine, P. O. Box 35260, Louisville, Ky. 40232

IN SURROUNDING STATES

SEPTEMBER

13-15 Cardiac Auscultation, University of Tennessee. Contact Mrs. Grace Wagner, UTCHS, 800 Madison Ave., Memphis, Tennessee 38163

29-30 Advanced Cardiac Life Support Course, Vanderbilt University, Nashville. Contact Carole Powell, American Heart Association, Suite 308, 1720 West End Building, Nashville, Tenn. 37203

OCTOBER

5-7 Diagnostic Radiology for the Primary Care Physician, CME, University of Tennessee. Contact LeRoy J. Pickles, Chattanooga, Tenn. (615) 756-3370.

12-15 "Diagnostic Imaging of the G. I. Tract," Society of Gastrointestinal Radiologists, Tan-Tar-A, Lake of-the-Ozarks, Mo. Contact Walter M. Whitehouse, M.D., Dept of Radiology, University of Michigan Hospital, Ann Arbor, Mich. 48109.

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MESSAGE FROM THE PRESIDENT

A Return to Basics — Hope for America

AMERICA grew great as a result of freedom and minimum government interference. Individual enterprise, the pursuit of work, productivity, and creativity resulted in the world's strongest nation and most dynamic people. Hard-earned capital purchased machines and equipment, enabling a consistent rise in the productive output of labor. Competition and the rewards and punishments of a free market, combined with sound fiscal government, provided stable prices for ever-improving products and services. Productivity, not consumption, is the key to economic stability and strength.

In the sixties, socialism became the dominant mood of our government. Redistribution of wealth achieved through confiscatory taxation was the central theme. Government became fiscally irresponsible, with every-increasing deficits financed by more paper dollars which inevitably destroys purchasing power. Labor used its political power to achieve more benefits and wages, despite decreasing growth of productivity. With the falling purchasing power of retained earnings and decreasing real returns on invested capital, business has been less able and motivated to purchase new equipment to raise productivity. Taxation has undermined the work ethic. Welfare rewards those who don't work; a tragedy, as work stabilizes lives by providing purpose, identity and security.

Recently, the airline industry has been released from many restrictions and competition has been restored. The result has been dramatic—a lowering of fare prices, a marked increase in business and profits, a surging demand for new aircraft, and creation of many more jobs.

There are other signs for hope. A demand for fiscal responsibility and reversal of confiscatory taxation has emerged. The economically disastrous Kennedy plan for National Health Insurance appears a dead issue.

Much remains to be done. Business needs the tax incentives to rebuild and modernize. Wage increases should be tied to the resulting growth of productivity and the increasing demand for labor as new jobs develop. Restrictive government must cease, competition restored, and inflation ended. Simultaneously, we can protect the environment, improve health care, allocate more resources for research and development, and take care of those truly in need. All of these goals can be accomplished if America returns to its basics of individual freedom and work.

JOHN P. STEWART, M.D.
KMA President

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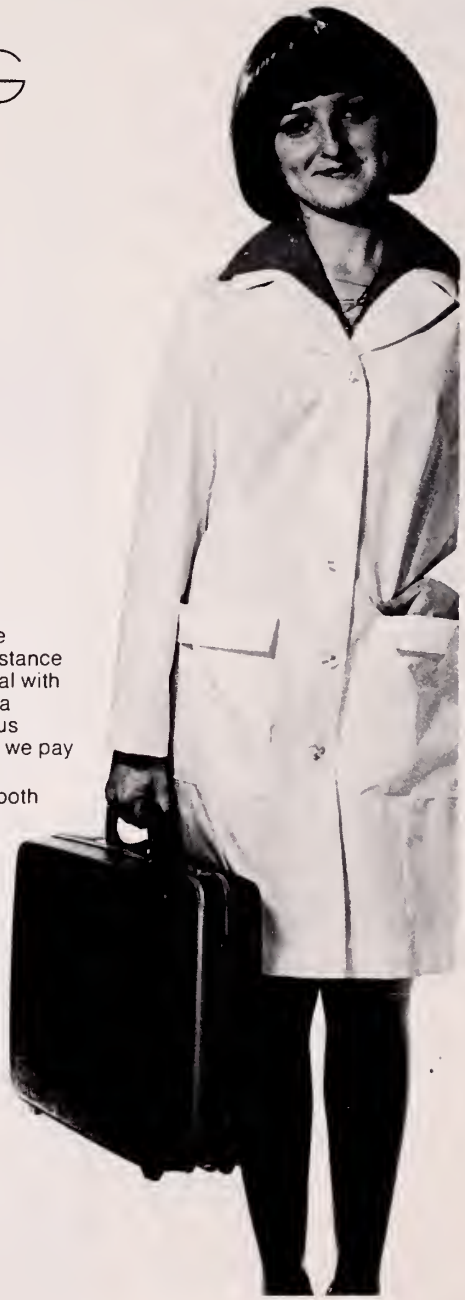

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A Link in the Chain

Mrs. Charles Nicholson, Lexington, was installed as President of the Auxiliary to KMA at its Annual Convention, April 25-26. She will write the "A Link in the Chain" page for The Journal during the 1978-79 Auxiliary year.

Mrs. Nicholson

THE Auxiliary held its Annual Leadership Conference in Shakertown, August 29. The Keynote Speaker was Larry Pickard, Director of Long Term Care, Lexington-Fayette County Health Department. His topic was "Assessing Health Care Needs in Your Community."

A parade of new project ideas were given by auxiliary members, including Meals-On-Wheels; Child Abuse; School Screening Prgram; Pediatric Hospital Orientation; Hello Daily; and Just-In-Case.

There were four workshops held: 1) Providing Community Health Education; 2) Providing Common Interest Groups for People with Health Problems; 3) Improving Health Care Through Local Government; and 4) Providing Supportive Health Care Services. A film on cardiopulmonary resuscitation was presented, as well as a Phoenix Workshop (Organ Donor).

The Leadership Conference Chairman, Jeanette Lucas, Lexington, and I hope that we were able, through this conference, to teach techniques to our county leaders and to stimulate them to start new health programs in their communities.

The Auxiliary Fall Board Meeting will be held in conjunction with the KMA Convention, September 26 and 27, at the Hyatt Regency Hotel in Lexington. There will be a hospitality room in the "Tree Top Lounge" to welcome all physicians' wives and their husbands. A luncheon, open to all wives, will be on Tuesday, September 26, at noon at Spindletop Hall. For reservations, contact Mrs. Richard Floyd at (606) 266-2895. A tour of Spindletop Hall and of the new Kentucky Horse Park will follow the luncheon.

There will be a reception for the incoming KMA President and the Auxiliary President at 5:30 p.m. on Tuesday, September 26. On Wednesday morning, there will be two special interest lectures: "A Look at Quilts," by Mrs. John Tuska, and "Renaissance of Two Short Street Homes," by Mrs. Richard C. Crutcher. Many tours are available and the women at the information booth will be glad to assist you with them. PLEASE join us; the Fayette County Auxiliary is delighted to be your hostess.

MRS. CHARLES NICHOLSON
AKMA PRESIDENT

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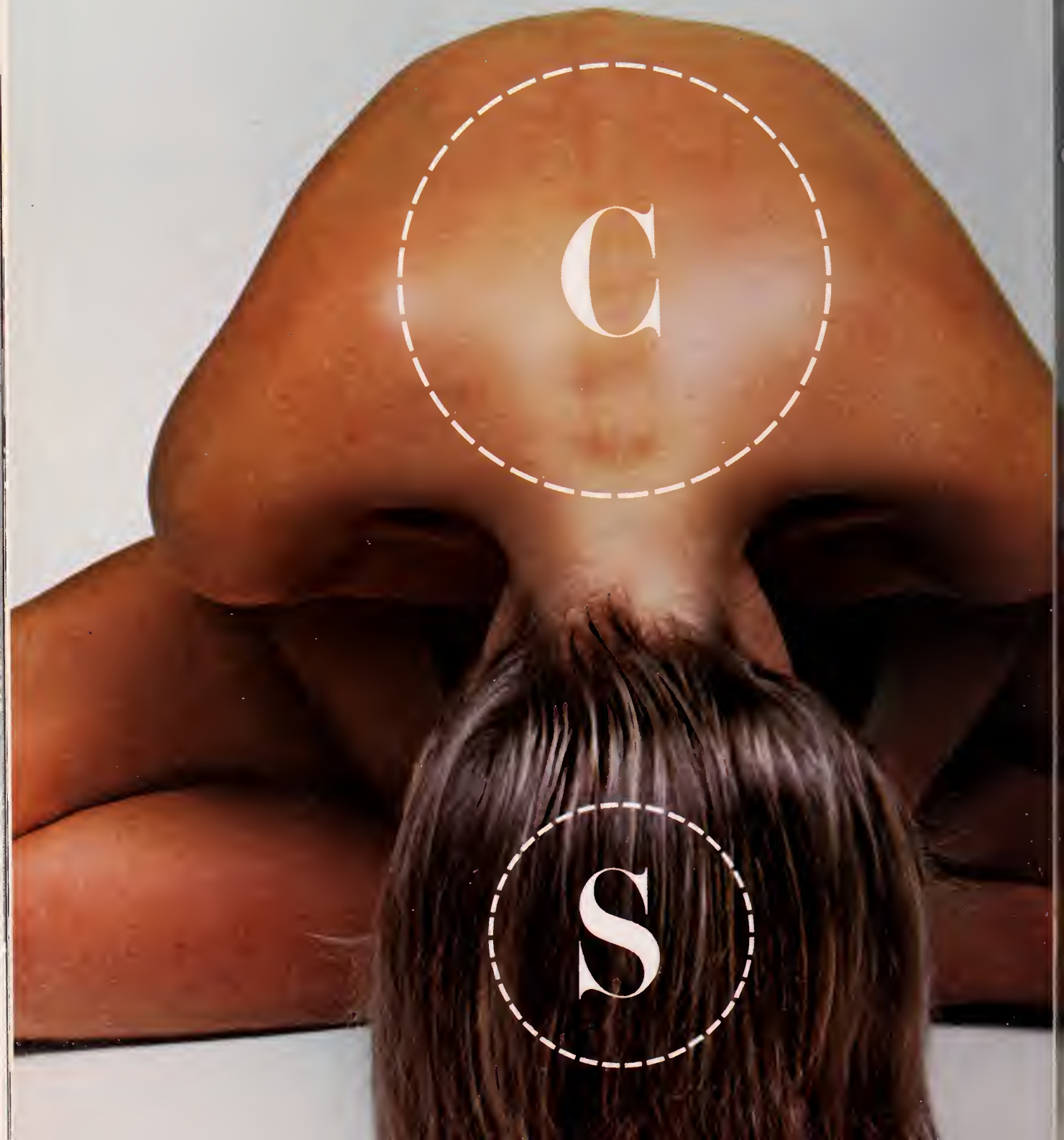

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Usage in Pregnancy—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticost roids—in some cases at rather low dosage levels. Therefore, dru of this class should not be used extensively on pregnant patient in large amounts, or for prolonged periods of time.

Occlusive Dressing Technique—The use of occlusi dressing increases the percutaneous absorption of cortic steroids. For patients with extensive lesions it may l preferable to use a sequential approach, occluding o portion of the body at a time. Keep the patient und close observation if treated with the occlusive tec nique over large areas and over a considerab period of time. Occasionally, a patient who h been on prolonged therapy, especially occl sive therapy, may develop symptoms steroid withdrawal when the medication stopped. Thermal homeostasis may l impaired if large areas of t body are covered. Disco tinue use of the occl sive dressing elevation of t body te peratu occu

Occasionally, a patient may develop a sensitivity reacti to a particular occlusive dressing material or adhesi and a substitute material may be necessary. If infecti develops, discontinue the use of the occlusive dre ing and institute appropriate antimicrobial therapy.

ADVERSE REACTIONS: The following local adve reactions have been reported with topical corticosteroi especially under occlusive dressings: burning sensatio itching, irritation, dryness, folliculitis, hypertrichosis, ac form eruptions, perioral dermatitis, allergic contact dermatit hypopigmentation, maceration of the skin, secondary infecti skin atrophy, striae, and miliaria.

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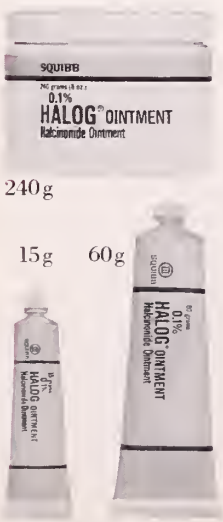

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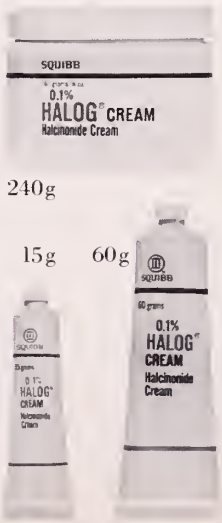

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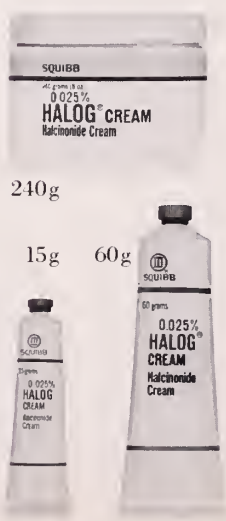

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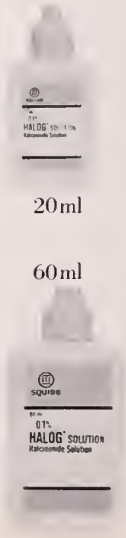

The JOURNAL of the
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Removal of Gastrointestinal Foreign Bodies with the Fiberoptic Endoscope

Patrick G. Brady, M.D.

Lexington, Kentucky

Twenty-three foreign bodies were removed from the gastrointestinal tract using a fiberoptic endoscope. They included large esophageal and gastric foreign bodies, and gastric bezoars. Fiberendoscopic treatment of foreign bodies is both safe and effective.

Removal of esophageal foreign bodies is most commonly performed with the rigid esophagoscope and frequently under general anesthesia. Surgical removal via gastrotomy has been the standard therapy for gastric foreign bodies which failed to pass through the pylorus spontaneously. With the recent technical improvements in flexible fiberoptic endoscopes, fiberendoscopic removal of gastrointestinal foreign bodies has become the procedure of choice in most cases. This report presents our experience with foreign body removal using a forward viewing fiberoptic endoscope in 24 patients.

Methods And Results

Since July 1975, flexible fiberoptic endoscopy has been utilized as the primary therapeutic modality in 24 patients with gastrointestinal foreign bodies.[1] Treatment by either removal or mobilization was successful in twenty-three patients (Table). In a single patient with a sharp metallic foreign body in the second portion of the duodenum, attempts at removal were unsuccessful. An Olympus forward viewing endoscope with either a single channel (GIF-Type D) was used in 22 cases, and an Olympus forward viewing endoscope with two channels (TGF-Type 2D) was used in two cases. A variety of forceps were employed depending upon the clinical situation (Figure 1). The ordinary endoscopic biopsy forceps was not generally useful in foreign body extraction and special foreign body forceps and snares were a necessity. No complications were encountered in this series.

Eleven esophageal foreign bodies were removed. The most frequently encountered problem was impaction of meat in the distal esophagus. Four patients presenting with this problem had an underlying esophageal stricture, one with severe

Table

FIBERENDOSCOPIC TREATMENT OF FOREIGN BODIES

1. Removal or mobilization from the esophagus:	
Nebulizer cover*	1
Impacted meat	7
Bones	3
2. Removal or mobilization from the stomach:	
Spoon*	1
Phytobezoars	10
3. Removal from the ileum:	
Long intestinal tube	1
TOTAL	23

*Previously reported in detail, Reference 1.

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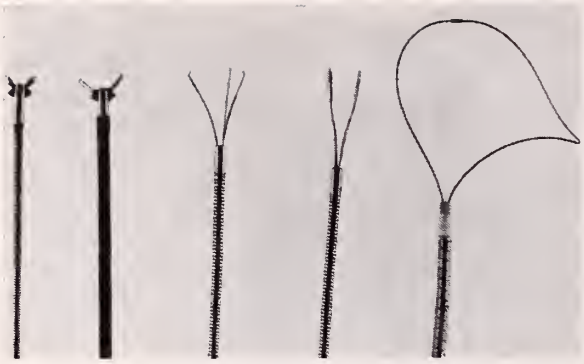

Figure 1: Accessories for removal of foreign bodies. Left to right: standard biopsy forceps, grasping forceps with alligator jaws, three pronged grasping forceps, grasping forceps for coins, wire snare.

esophagitis without a stricture, and two with normal esophagi. Both the alligator and three pronged type of forceps were useful instruments for removing meat. Difficulty was encountered in removing the bolus of meat intact in three patients who had been treated with meat tenderizer, or in whom endoscopy had been delayed more than 24 hours. In these cases, more than one passage of the instrument was necessary to completely remove the obstructing bolus.

Three bones and one nebulizer tip were also removed from the esophagus. Successful removal in these cases was accomplished by aligning the long axis of the foreign body with the long axis of the esophagus prior to withdrawal. In one instance, a fragment of bone was impacted at the cricopharyngeus. Safe removal of this object required introduction of the flexible endoscope under direct vision to avoid further trauma to the pharynx and proximal esophagus (Figure 2).

Gastric phytobezoars were encountered in 10 patients. Therapy consisted of endoscopic fragmentation of the bezoar followed by a clear liquid diet, and in several cases by oral cellulases. In all instances, the bezoars were completely mobilized following fragmentation. One patient developed a bezoar which failed to respond to oral cellulase therapy alone. On endoscopy, this bezoar had a hard, compact outer covering (Figure 3). Vigorous fragmentation with a wire snare and a biopsy forceps ruptured the outer coat of the bezoar, revealing a soft inner core containing numerous seeds (Figure 4). Following fragmentation, the remnants of this bezoar passed spontaneously.

A wire snare may be used to remove large foreign bodies which are difficult to grasp with a forceps. In this series, a spoon, 15 cm long and 3.4 cm at its widest dimension, was removed from the stomach by a snare. Likewise, a long intestinal tube with an inner coiled spring was removed through an ileostomy after being grasped with a snare. Removal of elongated foreign bodies of this type requires placement of the snare close to the end of the object so that, during withdrawal, the long axis of the object may align itself with the long axis of the viscus. To avoid the potential complication of perforation, traction should not be exerted on the presenting part of the foreign body without first determining what the result will be.

Discussion

Fiberoptic gastrointestinal endoscopy is recognized as a safe, valuable diagnostic procedure. However, the therapeutic potential of flexible fiberoptic endoscopy is not widely recognized. With the use of the wire snare,[2] and the development of forceps which allow firm grasping of large and slippery objects, the removal of foreign bodies with the flexible endoscope has become possible. A partial list of foreign bodies removed from the gastrointestinal tract includes catheters,[3] rings,[4] metal wires,[5] fruit pits,[6] pins and needles,[7-9] and razor blades.[10] The use of a protective plastic tubing placed over the endoscope allows safe withdrawal of sharp objects through the tubing, and protects the mucosa from sharp edges.[10]

The majority of ingested foreign bodies are passed spontaneously. Hoever, sharp or pointed objects may cause perforation,[11] and objects impacted in the esophagus result in obstruction and possible aspiration. Gastric foreign bodies larger than 2 cm in diameter, or longer than 5 cm, are unlikely to pass spontaneously. Gastric phytobezoars are associated with a high incidence of

Figure 2: Chicken bone removal from the esophagus at the level of the cricopharyngeus.

Figure 3. Gastric bezoar prior to endoscopic fragmentation.

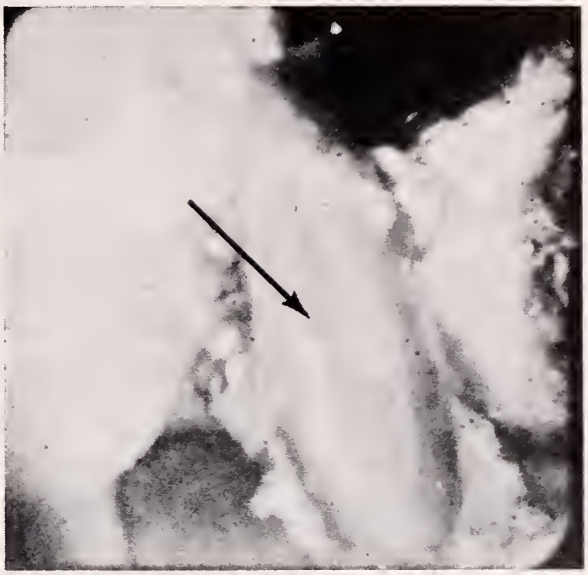

Figure 4: Gastric bezoar following fragmentation with a wire snare and biopsy forceps. A seed (arrow) is visable in the soft core of the bezoar.

complications. In these cases, an attempt at fiberendoscopic removal or mobilization is indicated.

There are no reports of complications resulting from fiberendoscopic foreign body removal; however, potential complications include perforation, hemorrhage and aspiration. Complications will be reduced and success enhanced with proper preparation. This should include simulation of the removal with a model, if possible, and review of the literature for experience with similar problems. General anesthesia is not necessary for fiberendoscopic foreign body removal providing the patient is cooperative. Premedication should be chosen to enhance patient cooperation. In this series, the patients received intramuscular meperidine and atropine thirty minutes prior to the procedure, and 1-15 mg intravenous diazepam immediately prior to the procedure. When the foreign body is impacted at, or just below, the cricopharyngeus, the endoscope must be passed through the pharynx and cricopharyngeus under direct visual control to avoid further mucosal trauma. Since impaction of a food bolus in the esophagus is frequently associated with the underling esophagitis, or stricture formation, the bolus should be removed rather than blindly pushed into the stomach.

Fiberendoscopic removal of foreign bodies has the advantages of greater patient comfort, avoidance of general anesthesia, and in some instances, avoidance of surgery. Ultimately, this results in greater cost effectiveness since hospitalization is either unnecessary or its total length reduced. A trial of fiberendoscopic removal of foreign bodies is warranted before proceeding to operative intervention.

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Overview of the Louisville Breast Cancer Detection Demonstration Project

Kirby I. Bland, M.D., Jerry B. Buchanan, M.D., James G. Kuhns, M.D., and Condict Moore, M.D.

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The Louisville Breast Cancer Detection Demonstration Project, nearing its fifth year of operation, has demonstrated proficiency in screening for breast cancer more than 10,000 asymptomatic women. At this point in the Project's operation, 97 carcinomas have been detected with subsequent identification of 25 interval cancers. A review of the application of screening, including the identification of minimal cancers and their prognostic significance, follows.

SINCE the inception of the Breast Cancer Detection Demonstration Project (BCDDP) in 1973, 27 such projects have been established under the sponsorship of the National Cancer Institute (NCI) and the American Cancer Society (ACS). These projects were established to demonstrate the expertise available in performing breast cancer screening in a widely dispersed geographic area throughout the United States. The justification for establishment of these programs was based solely on the study conducted by the Health Insurance Plan of Greater New York (HIP)[1,2] and funded by the NCI. Data from this study indicated that early screening with mammography and physical examination of the breast would reduce breast cancer mortality by 40%. However, corroborative data from these studies also indicated that only those individuals 50 years of age or older would benefit. The results were considered a valid basis for the application of screening techniques to a larger population with specific interest in determining the added value in screening individuals less than 50 years of age.

The BCDDP's have presently enrolled over 280,000 women ranging in age from 35 to 74 years for screening. After the initiation of the projects, concern was expressed in regard to the possible carcinogenic effect of radiation exposure to breast tissue. This led to an interim report on the lack of evidence for a proven benefit in screening asymptomatic women under age 50. Consequently, guidelines from the NCI restricted the use of mammography to those women who were in the 35-49 age group and who were at high risk for the development of breast carcinoma.

The data that follows represents the accumulated experience of the Louisville BCDDP after 55 months of operation.

Patient Material

Since August of 1973, there have been 10,132 women, ranging in age from 35 to 74 years, recruited for screening at the Louisville BCDDP. The modalities used for detection of carcinoma included clinical history, physical examination, x-ray mammography and thermography. To date, 97 carcinomas and 25 additional interval cancers have been detected. Thus, 122 total cases of breast carcinoma are available for analysis.

Clinical Assessment

A variety of examiners including resident physicians, practitioners, and nurse clinicians participated in the initial evaluation of the screenees. Of the 97 cancers detected, 42 were found at the

Table 1

CANCERS DETECTED AT THE LOUISVILLE BCDDP

Total Screenees		10,132
Cancers detected at scheduled examination		97
Initial visit	42	
Early recall	14	
Annual examination	41	
Cancers detected in the interval between scheduled examinations		25
Total cancers detected		122

From the Departments of Surgical Oncology and General Surgery (Doctors Bland and Moore), Radiology (Doctor Buchanan), and Pathology (Doctor Kuhns), University of Louisville, Louisville. *Doctor Bland's work supported in part by the American Cancer Society Junior Clinical Faculty Award (#436).*

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Table 2
FACTORS DISCLOSED BY CLINICAL HISTORY

Factor	No. of Patients
1. Nulliparous	17
2. First live birth at 25 years of age or later	41
3. Family history of breast cancer	21
4. Symptomatic (patient aware of lump at time of screening)	23

initial visit; whereas 14 cancers were detected at early recall, and 41 cancers were found at annual re-examinations (Table 1).

Demographic Data

The clinical history provided some interesting observations into the demographic background of the screenees (Table 2). Seventeen of the 97 patients with detected carcinomas had a nulliparity history, and 41 asymptomatic screenees had their first pregnancy at age 25 years or later. In retrospect, close analysis of the detailed histories reveals that approximately one-fourth of the screenees in whom cancer was detected were aware of some disorder in their breast at the time of the initial screening. Similarly, a large percentage (22%) of screenees admitted to a strong familial history of breast cancer in their mother or a first degree relative.

Diagnostic Method

Table 3 delineates the diagnostic modalities employed for detection of the carcinomas. Mammography remains the most accurate diagnostic method, and is followed respectively, regarding accuracy, by physical examination and thermography. Further observation disclosed that mammography alone detected 24% (23 of 97) of the true positive lesions and 57% of the cancers associated with histologically negative axiliary nodes. Thus mammography alone, or in combination with physical examination and thermography, identified 92% of the carcinomas detected in the Project.

Table 3
DIAGNOSTIC METHODS

Modality	True Positive
PE	5
PE, T	3
PE, M	26
PE, M, T	19
MT	21
M	23
T	0
All Negative	0
	97

PE = Physical Examination
T = Thermography
M = Mammography

Histopathological Factors

Twenty-seven of the 97 screenees with detected carcinoma were less than 50 years of age. In five of these patients (18.5%), histological examination of axillary node specimen was positive. Thirteen screenees in the under 50 age group had interval cancers; five (38.5%) had histologically positive axillary nodes.

The histopathologic types of both detected and interval cancers are outlined in Table 4. The invasive lesions were much more prevalent in the total group than were *in situ* lesions. Interestingly, 73% of the patients with detected and interval cancers had histologically negative axillary nodes in the 108 axillary dissection specimens. Histologically positive nodes were observed more commonly in patients with interval (false negative) cancers.

In the 55 months of operation of the Louisville BCDDP, 1,731 biopsies have been recommended; 823 have been performed. One hundred twenty-two cancers were confirmed, representing a confirmation rate of 15%.

Surgical Procedure and Follow-up

Radical or modified radical mastectomies were performed more frequently (84%) for definitive therapy than any other procedure (Table 5).

Table 4
HISTOPATHOLOGIC TYPES OF 122 CANCERS DETECTED
(AUGUST 1973 - JANUARY 1978)

		In Situ Cancers	Invasive Cancers		
				Nodal Status	
Total Cancers Detected		No. of Cases	No. of Cases	Negative	Positive
True positive	97	11	86	65 (76%)	21 (24%)
False negative (interval)	25	3	22	14 (64%)	8 (36%)
	122	14	108	79	29

Table 5

OPERATIVE THERAPY PERFORMED IN 122 CASES OF BREAST CARCINOMA

Procedure	No. of Patients	
Mastectomy:		
Radical	44	103 (84%)
Modified	59	
Simple	14	
Partial	5	

To date there have been no deaths in any of the patients less than 50 years of age, and four deaths in those greater than 50 years of age. Followup of the interval from detection of the carcinoma to definitive treatment ranged from 10 to 55 months. None of the patients less than 50 years of age have evidence of recurrent disease. Five patients over 50 are living with metastasis (Table 6).

Minimal Cancers

"Minimal" cancers are defined as either noninfiltrating (in situ) carcinoma or infiltrating carcinomas measuring less than 1 cm in diameter. Following accumulation of data from all BCDDP projects, the BCDDP Pathology Review cohort tabulated all such cases for which biopsy had been recommended prior to June 30, 1976. Table 7 compares the total cancers detected in the National BCDDP's and the Louisville Project. Eighteen minimal carcinomas were detected in our Project. Of these 18 cancers, 12 (67%) were positive only on mammogram. None of the minimal carcinomas were detected exclusively by thermography or physical examination.

Table 6

POSTOPERATIVE FOLLOW-UP

Age Group	Metastases (Living With Disease)	Death
<50 Years	0	0
>50 Years	5	4

Of the total 18 minimal carcinomas detected, seven (39%) were invasive primary tumors less than 1 cm in diameter; whereas, eleven (61%) were *in situ* lesions. Seven minimal cancers were detected in the screenees less than 50 years of age, of which four were invasive histologically. Mammography was the sole modality for detecton of **all** carcinomas in this group.

Comments

Since the efficacy of breast cancer screening in women over 50 years of age has been demonstrated by HIP study,[1,2] much attention has been focused at the national level concerning potential benefit to the under 50 age group. Data currently accumulating from the national projects strongly suggests benefit for screenees in the 35-49 group.[3] Clearly, mortality associated with breast cancer has not been greatly altered since the original demonstration of the efficacy of the Halsted radical mastectomy. Only by early detection and subsequent reduction in the primary staging of the detected lesion will mortality and survival rates and the quality of survival be altered.

Data tabulated in the Louisville BCDDP strongly suggests that the benefit derived from

Table 7

CANCERS DETECTED BY PROJECT: POSITIVE MODALITY NATIONAL BCDDP VS. LOUISVILLE BCDDP

	NATIONAL*	LOUISVILLE**
A. Total Cancers Detected at Scheduled Screening	966	97
Positive on MM only (PE neg and therm neg)	285	43
Per cent of total	30%	44%
B. Total Minimal Cancers***	359	18
Positive on MM only (PE neg and therm neg)	139	12
Per cent of total	39%	67%
C. Total Negative Nodes****	601	65
Positive on MM only (PE neg and therm neg)	177	37
Per cent of total	30%	57%

* Data from first screening and second screening
** Represents data collected after fourth screening
*** Includes cancers reported as noninfiltrating and infiltrating under 1 cm.
**** Based on 86 axillary dissections for 97 cancers

screening; i.e. reduction in both tumor size and number of positive nodes, is applicable to all age groups. Our data indicate that interval carcinomas are associated with a higher incidence of histologically positive axillary nodes and appear with the same relative frequency in younger and older age groups.

Mammography remains the most sensitive detection modality in all age groups; whereas, thermography is the least sensitive method of detection of carcinomas in the asymptomatic screenee. Minimal carcinomas can be identified via the screening process and appear with similar frequency in all age groups.

Analysis of the demographic data and the high number of detected carcinomas indicate that women can be selected in a manner that produces maximum efficiency in the screening process. Perhaps benefit-risk analysis, with patient selection in combination with the screening modalities described, will allow ultimate reduction in the morbidity and mortality of breast cancer.

Acknowledgments

The authors acknowledge the contributions of Ms. Alice G. Milner, Project Coordinator; Ms. Peggy J. Dawson, Pathology Coordinator; Doris Burger, R.N., and Charlotte Lesshaft, R.N., Nurse Clinicians.

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Bromide Intoxication: A Persistent Problem

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Louisville, Kentucky

Bromides are effective drugs for the treatment and control of anxiety and insomnia. They enjoyed popular use for over a century, until supplanted by safer and more effective sedatives. Bromide intoxication, although today relatively rare, continues to be a problem because several bromide-containing drugs are still marketed and available for physicians to prescribe as sedative-hypnotics.

Case Report

B. G., a 35-year-old white male was admitted to the Dermatology Service on June 6, 1975, with bilateral leg lesions, later diagnosed as erythema nodosum. Eleven days later, a psychiatric consultation was requested, primarily for the assessment of a suspected personality disorder and sexual impotence. On initial interview, the patient was found to be lethargic and to exhibit slurred speech and ataxia. An impairment of both content and continuity of thought were found. Only a limited amount of history could be provided by the patient. He appeared, at times, to be confused and his memory seemed poor, but he was relatively well oriented. Further history obtained from the patient and his family revealed two previous psychiatric hospitalizations, in 1970 and 1973, when he was treated primarily with major tranquilizers. He had lost contact with his private psychiatrist for over a year, and for approximately the last six months, had been medicating himself with "Nervine." A blood bromide level obtained immediately after consultation, two weeks after he had first entered the hospital, was 236 mg%.

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Pharmacology

Bromide poisoning is attributed to chronic ingestion of sodium or potassium bromide. Acute overdose is rare because the bromide ion causes gastric irritation and emesis usually follows.[1] The bromide ion is reabsorbed by the kidney more efficiently than is the chloride ion. The slow excretion of bromide by the kidney, coupled with chronic ingestion leads to the accumulation in the body. In bromide poisoning, the halide concentration will be increased, causing a "false" increased chloride concentration, a clue to early diagnosis. Bromide accumulates more readily in the malnourished and debilitated. Alcoholism may disguise underlying clinical signs of bromism.[2]

Recently, bromides were removed from all nonprescription sedative-hypnotics, including "Nervine." However, there are several drug products in the United States today, available only by prescription, that contain high levels of sodium, potassium, or ammonium bromide (Table). Most of these drugs contain more bromide salts than the "old Nervine." The exact bromide toxicity level is debatable, but the literature generally agrees that levels above 150 mg% are toxic; above 300 mg% can be lethal. Deaths from chronic bromide poisoning are infrequent, but have been reported. A bromide level above 50 mg per 100 ml in a susceptible patient can account for the symptom picture of bromide poisoning.

Table

BROMIDE-CONTAINING DRUGS IN THE U.S. (1978)

A. Prescription
   1. Ureides
      a. Carbomal (Cabromal®)
      b. Bromisovalum (Bromural®)
      c. Acetylcarbromal (Paxarel®, Sedamyl®, Carbased®)
   2. Other Sedative-Hypnotics
      a. Fello-Seds®
      b. Neurosine®

B. Nonprescription
   None

Clinical Picture

The signs and symptoms associated with bromide intoxication can be related to three systems: 1) the central nervous system, 2) the gastorintestinal system, and 3) the skin. The psychiatric symptoms are those commonly found in any organic brain syndrome. These include impairment of speech, memory, handwriting, sensorium, orientation, intellectual capacity, and emotional control as well as tremulousness, ataxia, and dysarthria. Delusions and hallucinations can occur, reflecting either the patient's premorbid personality or other mental illness. Hyperactivity, sluggish or absent deep tendon reflexes, generalized weakness, varying degrees of drowsiness, and absence of sexual desire are seen.

Gastrointestinal symptoms include anorexia with weight loss, nausea, and vomiting. Dehydration may occur. The classic cutaneous sign of bromism is the pustule studded, ecthyma-like plaque on the legs. Multiple lesions may be seen. Early lesions include papules, pustules, edematous plaques, and later, ulcers. Occasionally, nodular lesions, such as seen in this case, are encountered. Some laboratory investigations, aside from the serum bromide, may be abnormal during the course of the illness. These include electrolyte disturbances with a relative increase in chlorides and potassium. There may be slight increase of protein, pressure in the cerebrospinal fluid, and electroencephalographic changes can be present.

Treatment

General supportive treatment for bromide intoxication will vary with the severity of symptoms. However, the basic plan should include: 1) abrupt withdrawal of bromides, 2) high fluid intake, 3) proper diet, 4) sedation if necessary (chlorpromazine or minor tranquilizers) and 5) investigation of the underlying emotional disorder for which the patient originally took bromides.[3]

Specific treatment is directed toward enhancing bromide excretion. Hemodialysis has been used for the treatment of lethal doses. Diuretics also rapidly decrease the serum bromide concentration. A less aggressive measure for toxic patients is the use of sodium chloride, four to eight grams daily given in divided doses. Ammonium chloride has also been used, since it not only provides extra chloride for displacing bromide, but also acts as a diuretic. A recent article described a case of bromide intoxication in which treatment with a combination of diuretics yielded impressive results.[4]

Discussion

Some clinical features of the case presented need to be reviewed briefly, in order to highlight how patients are not served well if the primary doctor lacks knowledge of bromide intoxication. How this patient reached our service is important. He was admitted to the dermatology service for attention to his skin lesions. On admission, because there was obvious physical pathology, his mental status was ignored or minimized. Whether the skin lesions present in this patient were associated with the bromide intoxication is debatable. Skin lesions with bromism are often mentioned in the literature, and the rash given the special name of "bromoderma." Nevertheless, it is important to keep in mind that bromism can present as only a rash.

Why the attending medical staff wanted the psychiatric consultation is also remarkable. The referral source desired mainly an evaluation of the patient for his symptoms of genital erection dysfunction. As has been mentioned, bromism can lead to a decrease in sexual energy. If, in his evaluation, the consultant overlooks certain features of the history and mental status examination, the diagnosis may be inaccurate.

Summary

In conclusion, we find that patients who are taking sedative-hypnotics containing bromides seek treatment at emergency rooms and psychiatric clinics. Diagnosing the illness is not difficult, as long as a high index of suspicion is maintained. Essential for the diagnosis is the history of ingesting bromide-containing drugs. In the past the culprit was often Miles Nervine. The new Nervine, available now in capsules, contains methapyrilene, a weak antihistamine. Methapyrilene, alone or in combination with scopolamine, rilene, alone or in combination with scopolamne, is the active drug found on most nonprescription sedative-hypnotics now available.[5] Although today most patients with positive blood bromide levels are taking the drug by prescription, the "old Nervine" which contains bromide can still be found at the counters of some supermarkets

and drug stores. It would be imperative, in specific cases where bromism is at issue, to ask the patient about nonprescription remedies as well.

Once bromism is diagnosed, the treatment usually is rather simple, and for nonlethal doses a conservative approach seems preferable. Often the most difficult part is to deal therapeutically with the underlying disorder that caused the patient to begin ingesting bromides.

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GRAND ROUNDS

University of Louisville School of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

Aorticoduodenal Fistula Secondary to a Toothpick

We recently treated a young man with massive upper gastrointestinal bleeding. Several points about this patient are worthy of comment.

Report of a Case

A 22-year-old man began to complain of back pain about three weeks before his hospitalization. He had a temperature of 38.9°C and vomited bright red blood on one occasion. He was admitted to another hospital after fainting; he was found to have massive uppergastrointestinal (UGI) bleeding and required six units of blood. His temperature was 40°C at that time.

The patient was transferred to our hospital with continuous profuse hematemesis and upon arrival sustained a cardiac arrest from which he was successfully resuscitated. Bleeding ceased, and an aortogram with selective celiac axis views disclosed no evidence of a bleeding site at that time. An upright abdominal film demonstrated retroperitoneal gas which appeared to outline the pancreas. While being prepared for operation, the patient sustained another massive UGI hemorrhage. A total of 16 units of blood was given, and he was taken to the operating room with a suspected diagnosis of necrotic pancreas or retroperitoneal abscess of unknown origin. Diffuse hemorrhagic gastritis was the suspected source of upper gastrointestinal bleeding. His condition was never stable enough to perform esophagogastroduodenoscopy.

At celiotomy, the patient was found to have a retroperitoneal mass. Gastrotomy was quickly performed; the gastric mucosa was entirely normal. Massive hemorrhage from the third portion of the duodenum was controlled with direct pressure. Dissection of the retroperitoneal mass disclosed an abdominal aortic aneurysm which was foul smelling and obviously necrotic. An aorticoduodenal fistula was present. Superior and inferior control of the aorta was obtained and the duodenum dissected from the fistula. There was a 3 cm opening in the duodenum. In resecting the necrotic wall of the aorta, a wooden toothpick was found lying entirely free within the aorta. The aortic wall was resected to remove as much of the infected material as possible. The aorta was then oversewn below the renal arteries, the iliac arteries were ligated distally well away from the infectious process, an extra-anatomic shunt was performed, and the duodenal defect was closed. An axillobifemoral graft supplied good flow to the legs. Neither the patient nor his family was aware that he had ever swallowed a toothpick. Unfortunately, the patient died three days after operation of overwhelming sepsis. Permission for autopsy was denied.

Discussion

A number of case reports illustrate the hazards of toothpick ingestion, including a recent fatality from a duodenocaval fistula secondary to a toothpick[1]; however, a previous report of aorticoduodenal fistula secondary to such a foreign body could not be found. Although we were unable to save this patient, the case does illustrate several points. First of all, the patient did have a sentinel bleed which is common for most patients with aorticoduodenal fistulas regardless of causation. Even in a person as young as this patient, exsanguinating UGI bleeding should suggest the possibility of a communication between the aorta and the duodenum. Secondly, the reconstruction of this patient's vascular system with an axillofemoral graft and resection of the involved aorta appeared to be the only treatment under the circumstances and his grafts were open at the time of his death. Finally, this case, along with other reports in the literature, would suggest that the ingestion of a toothpick is not always followed by its benign passage through the gastrointestinal tract.[2,3] Although many physicians have become cavalier in the management of ingested foreign bodies, we suggst that any person who has swallowed a toothpick be observed very closely.

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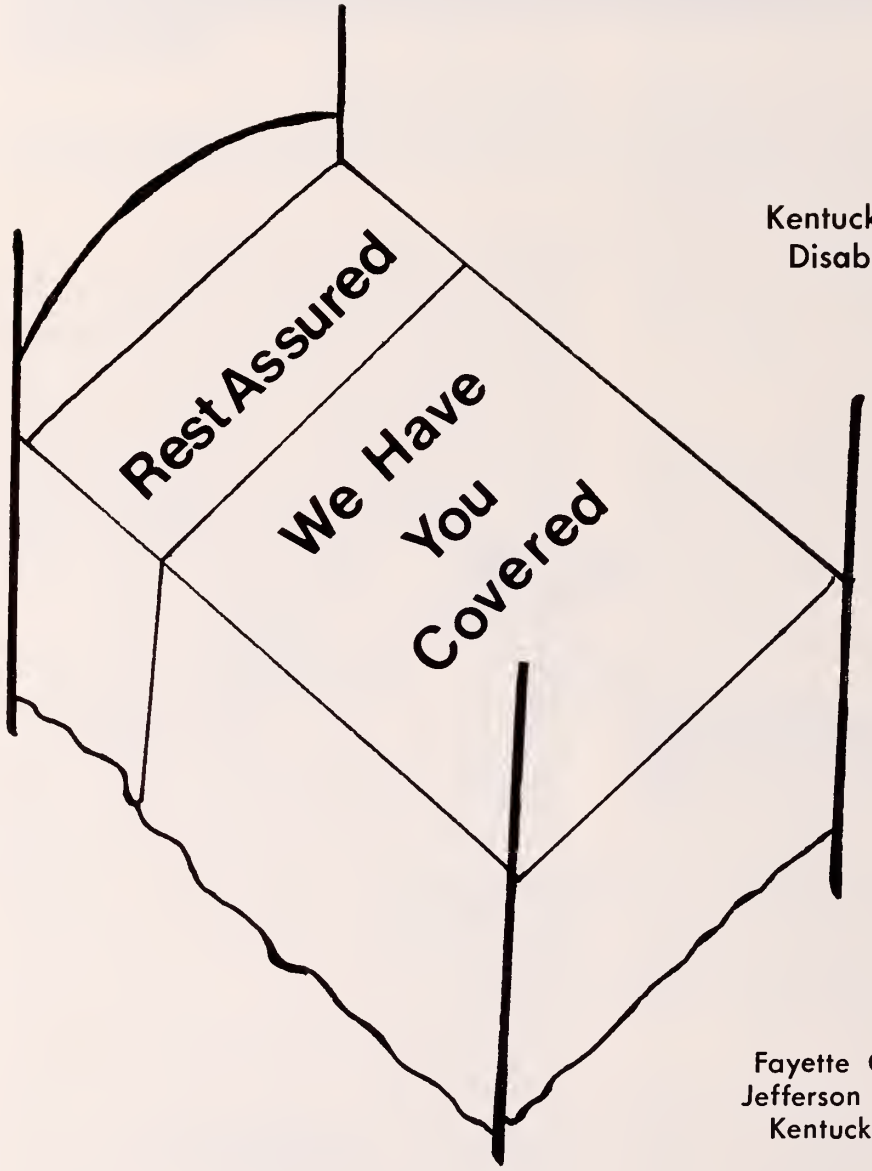

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Clinical Observations

Photolocalized Varicella

GORDON B. NEWELL, M.D.

Several viral dermatoses are aggravated by and limited primarily to areas of sun exposure. Recurrences of herpes simplex infections are often triggered by sun exposure.[1] Sixty percent of patients with chronic lymphogranuloma venereum in one study were photosensitive.[1] Echo 9 viral exanthems have shown a photodistribution.[2,3] Photosensitivity has occurred following smallpox vaccination.[4,5] In one series, a combination of a sulfanilamide (a photosensitizer), vaccinia virus (postvaccination) and sunlight resulted in a photosensitive dermatitis in 28.9 percent of patients.[6] Less well-documented photoaccentuation of viral exanthems has occurred in patients with rubella and concurrent measles and Coxsackie A9.[3]

The purpose of this report is to document a case of varicella limited to sun-exposed areas. Possible explanations for the photodistribution will be reviewed.

Report of a Case

A four-year-old Caucasian female, in otherwise good health, was referred by her pediatrician because of an excoriated maculopapulopustular eruption on the sun-exposed areas of her face and trunk of four days duration (Figure 1,2). The exposed areas were slightly tanned but no solar erythema was present. The dermatitis began the day after returning to Kentucky from a trip to Florida. She had been treated elsewhere with betamethasone and hydroxyzine systemically and a hydrocortisone lotion. The clinical diagnosis was varicella and a Tzanck smear revealed multinucleated giant cells. She was treated with an antipruritic shake lotion and the hydroxyzine syrup was continued. The eruption resolved uneventfully over the next two weeks.

Comment

Alford[7] noted that localized areas of inflammation may predispose to an increase in the number and size of varicella lesions. Richardson[8] reported the accentuation of varicella following sunburn during the incubation period. Castrow and Wolf[9] reported a similar case in 1973 and proposed the term "photolocalization" for this phenomenon. Gilchrest and Baden[2] later added a third

Figure 1. Anterior view of patient with photolocalized varicella.

Figure 2. Posterior view of patient.

case and noted the paucity of reports at that time of photodistribution of viral exanthems. Cupoli[10] reported photolocalized varicella in two adoptive siblings.

Mims[11] noting that large viruses such as varicella exist intracellularly in leukocytes and in platelets, suggested that the virus could reach dermal and epidermal cells via diapedesis of infected yet functional lymphocytes. In general, four possible explanations for photolocalization of varicella have been offered.[2,9] First, ultraviolet light-induced inflammation may cause increased diapedesis of leukocytes, increased vascular permeability and increased adherence of platelets to endothelial cells. This would result in increased numbers of viral particles in sun-exposed skin. Secondly, ultra-violet light-induced vascular dilatation causes increased profusion of sun-exposed areas. Consequently, more viral particles would reach these sites. Thirdly, ultraviolet irradiation might facilitate viral replication in the skin by an unknown mechanism. Finally, if the viral particles were in melanocytes, as has been reported with herpes simplex,[12] skin exposed to ultraviolet light might be preferentially affected because of increased melanocyte activity.

It is hoped this report will increase awareness of this apparently uncommon phenomenon.

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SPECIAL ARTICLES

A Blueprint of Change

D. Kay Clawson, M.D.

THROUGH a series of intense efforts, faculty and administrators of the University of Kentucky College of Medicine and officials of the University administration, have begun to address a number of concerns which have been developed and expressed by the College of Medicine over the past three years.

This article identifies these concerns, along with the steps that have been taken, to address each area.

In the spring of 1977, a faculty committee of the College of Medicine presented a document expressing its concern about a number of conditions in the Medical School. These included:

1. An increase in services without a corresponding increase in resources or the size of the faculty;
2. An erosion of the academic environment and loss of competitiveness in recruiting new faculty members;
3. An increased dependency on fee-for-service income without full recognition of the role of the individuals responsible for income generation with regard to income utilization.

It was the feeling of the faculty that more financial support was needed from the State to support the current level of activity as well as the expanding and developing programs of the College.

At the time the faculty document was presented, the University had been working with an external consultant for six months in evaluating the financial support and the practice plan of the College. After reviewing the faculty's concerns, the University and Medical Center Administration, in concert with the Medical Center Committee of the Board of Trustees, began an extensive fact-finding effort to: assess the quality of the academic program; review the professional practice plan; study the organizational structure for hospital governance; and assess the level of state financial support. In addition, such issues as tenure commitments, academic governance and physical space were to be analyzed.

Two fact-finding teams consisting of representatives from the Office of the President, the Vice President for the Medical Center, the Dean of the College of Medicine and faculty representatives surveyed nine benchmark medical schools in surrounding states. This study was completed in July 1977.

The findings in this survey documented that some indicators place the College of Medicine at a disadvantage in certain areas in relation to benchmark comparisons. It demonstrated that the ratio of total students to individual faculty was greater than most benchmark institutions. It further demonstrated that faculty definitely have a greater responsibility for more patients than the majority of the benchmark institutions and that they care for the highest number of outpatient and emergency patients per faculty member of all the institutions. UK faculty were second highest in number of inpatient admissions per faculty of the surveyed institutions. The College not only generated the next highest practice income per clinical faculty, but it was still able to maintain an average position in terms of federally sponsored grants. While there were a variety of practice plans, and no two schools were alike, there was a common theme that allowed faculty to have more input into the distribution and use of practice income than was the case at UK. In addition, findings related to space disclosed that UK was more than 100,000 net square feet of space below the next lowest institution.

Consequently, the findings related to inadequate space were addressed in the biennial budget request of the University, since it was readily apparent that the previous biennium approval of a new Primary/Ambulatory Care Center would only address one problem and would not provide the space necessary for other College programs to maintain a competitive position.

It was further deemed impractical to provide all the necessary space in one biennium. Therefore, $7.5 million was requested for construction of a new research office and space addition. Bonding authority was requested to expand and modernize the University Hospital in order to provide additional space for the clinical faculty, meet the needs of the clinical teaching program, and provide expanded services such as the neonatal care program.

A task force also began looking at Hospital governance and ways in which the governance could be made more in keeping with the recommendations of the Joint Commission on Accreditation of Hospitals. On April 4, 1978, the Board of Trustees authorized the formation of a Council of Supervisors as the governing body of the University Hospital to be composed of members of the faculty, administration, Board of Trustees and lay members of the public-at-large. The Council of Supervisors would be responsible through the President to the Board of Trustees, but would handle most of the routine administrative matters involving the Hospital operation and organization. A new set of By-Laws was likewise approved.

Another task force began looking at the financial operation of the College and a possible new practice plan.

Dean of the University of Kentucky College of Medicine.

On January 16, 1978, a new practice plan concept was circulated to the faculty. Subsequently, a ballot vote was conducted by the Faculty Council. The results showed that of the 219 faculty who voted, 86% were in favor of a new plan and that 81% endorsed the concepts circulated in the faculty document. This document called for:

1. An increase in State support of approximately $3.5 million;
2. A recognition of the different sources of support by separating the State support from earned income;
3. Committing the University for tenure to a level supported by State dollars rather than the total compensation;
4. More input from the faculty regarding how earned monies were distributed and what programs would be underwritten by practice dollars.

On March 24, 1978, in a letter to the Vice President of the Medical Center and Dean of the College of Medicine, UK President Otis A. Singletary outlined a charge to the Medical Center administration and the faculty for developing a detailed plan that would embody the following basic principles:

1. The plan must be sound, equitable and reasonable;
2. The plan must be justifiable as being in the best interests of the institution, the citizens of the Commonwealth, the affected faculty and programs;
3. The plan must fit the financial resources which the State has been able to provide to the University;
4. The plan must not compromise the basic status of present faculty who choose not to make a change;
5. The plan must make accountability to the University and other appropriate publics a clearly stated and functional objective. To this end, the books, records and accounts must be open at all times to inspection and audit by the University.
6. The University's involvements and agreements with an outside entity will make necessary careful delineation of profesional income and its attendant costs to avoid even the appearance of diverting University funds into an outside organization.
7. The plan must not be in conflict with applicable laws under which the University and all of its component units must be governed nor with basic principles on which academic institutions operate.

Multiple teams were established to work on the details of this new option. The first one resulted in the filing of the Articles of Incorporation of the Kentucky Medical Services Foundation, Incorporated, on June 17, 1978. Purposes for which the corporation was organized are:

- to coordinate and develop superior patient care and group practice setting within the academic environment of the University of Kentucky Medical Center, including the provision of financial support for its teaching, research and service programs, and to the personnel and equipment necessary for such programs;
- to execute and perform a public trust in supporting, aiding and advancing the study and investigation of human illnesses and injuries as well as the causes, preventions, relief and cure thereof, and the study and investigation of problems of hygiene and health;
- to encourage, promote and perform medical, surgical and scientific learning, skill, education and investigation;
- to attract and retain high quality faculty to teach, conduct research and provide patient care;
- and in furtherance of the above purposes, to use and apply the whole or any part of income and principal exclusively for charitable, scientific, or educational purposes at or for the benefit of the UK Medical Center.

On June 20, 1978, the Board of Trustees approved the resolution for establishing a geographic full-time medical service plan for members of the faculty electing this option, but preserving the existing Physicians' Service Plan (PSP) for those faculty who wished to remain in it.

Under the PSP, the University established a salary for each individual faculty. This salary consisted of monies derived from State allocations, tuition, salary reimbursement from grants and contracts, and a grant from the physicians' earnings. Although a large portion of the money (in excess of $4 million) was derived from physicians' income, the total salary was tenured. In addition, the University billed, collected and distributed all funds through a Board that obtained advice from faculty and College of Medicine administration, but the latter had no direct representation on the Board.

Many activities such as medical/legal services and certain consulting services were excluded and income derived from those sources by faculty members could be retained personally as income above their salaries. In addition, a bonus system allowed distribution twice yearly of income above the operating expenses, not to exceed a maximum of 25% of the aggregated clinical faculty salaries. Such distribution did not directly follow patterns of earning, but remained at the discretion of department chairmen and the Dean of the College.

Under the new plan, the tenure commitment for salary is established by the Board of Trustees and is considerably less than the previous salary tenure commitment. All clinical income, regardless of source, is directed to the Kentucky Medical Services Foundation, Inc., which is operated by a 10-person Board of Directors, five individuals by virtue of their University position in the Medical College and five elected by the faculty. (On July 7, the Board of Trustees approved the contractual agreement between the University and the Kentucky Medical Services Foundation, Inc., as called for in the plan.)

The Foundation, in addition to meeting its operating expenses, will also pay 10% of the gross earnings to a College academic enrichment fund. These funds are to be used by the Dean for enrichment of College of Medicine programs. With the exception of these expenses, there will be no co-mingling of funds between academic departments. Each department may have its own practice plan for distribution of income. The income distribution plan, however, must be approved by the Dean of the College and the Vice President of the Medical Center.

Each plan must further set aside funds to be used at departmental and divisional discretion for academic enrichment activities. The funds can be used to hire additional secretaries, laboratory technicians, fellows and for student scholarships. An important feature of the plan is that the faculty must confine their clinical activities to the University Hospital, University affiliates, and approved programs, except in those rare instances where emergencies or medical ethics demand otherwise.

(Continued on page 452)

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EDITORIAL

A Realistic Mammography Perspective

I am greatly concerned about the recent publicity regarding mammography and radiation hazards. Current critics of the mammographic examination have predicted that annual mammographic screening of women, beginning at age 35, could theoretically induce breast cancer in a small number of these women following an unknown latent period (10-30 years).

It is most important to emphasize, I feel, that the indicated or diagnostic mammographic examination is NOT dangerous and should be considered an integral part of the complete breast exam. Many women are alive and healthy today only because they once had such an examination. Countless others have added years to their lives because a cancer that could not be detected by any other means was discovered at a very early stage using the breast X-ray examination. According to the best scientific information available to date, the small amount of radiation used during such an examination has never caused a single breast cancer. Furthermore, should such a hypothetical cancer be induced, I am confident it would be detected quite early, requiring at most only conservative treatment with an excellent prognosis. With today's methods of treatment, the most severe result would be the loss of a single breast in the later years of life. This rare occurrence of a cancer that could be readily and successfully treated must be balanced against the omission of an indicated mammogram in a patient in her 30's or40's, which allows a cancer to go undetected and results in her death at a very young age.

A proper perspective can be gained only by looking at what is hypothetical information and what is factual. The risk proclaimed by mammography critics is strictly hypothetical and is based on extrapolation of data from studies of three population groups which involved high levels of radiation given to young women at close intervals. The critics analyzed data from three groups: 1) Young women who received multiple chest fluoroscopies during the treatment for pulmonary tuberculosis, 2) A small number of young women receiving radiation for treatment of post-partum mastitis, and 3) Those Japanese women who survived the atomic bomb. Using this data, they then made a prediction of approximately six excess breast cancers per million women screened per rad per year. But because this figure was derived through extrapolation, it is merely an assumption; even if accurate, the effect would not become apparent until a latent period of at least ten years.

Now for some facts. The benefit from screening for breast cancer has been proven in women over 50 years of age. The carefully controlled study which demonstrated a benefit was the well-conceived HIP Study of greater New York. In this program, now in its ninth year of follow-up, a 45% reduction in mortality was demonstrated in those women ages 50 and older whose breast cancers were detected during annual screening. This same benefit was not clearly demonstrated in those women under age 50. However, due to the mammography techniques used in the early sixties, very few cancers were found in the younger population. It is expected that the accuracy of mammography at that time would be reflected in the older population group with the less dense, fatty and atrophic breasts. It seems to follow that a significant benefit would then be demonstrated in only those women where mammography made a substantial contribution to the early detection.

One other data source now available allows us to predict a comparable benefit in women under age 50. This information is derived from the data accumulated by the 27 Breast Cancer Detection Demonstration Projects begun in 1973 and 1974. This national screening experience found over 70% of the screenees with occult breast cancer, whose surgical procedure included nodes which could be histologically examined, free of axillary node metastases. Many of the

screenees, because of early detection, elected to have a limited surgical procedure and are therefore excluded from the negative node category. Thus, the actual number of screenees with negative axillary nodes is probably in excess of 70%. Node status has historically been the single most important parameter in determining ultimate survival.

Mammography was the single most sensitive indicator of the occult lesions, alone leading to the diagnosis in 45% of the screenees. Of the minimal breat carcinomas thus far confirmed by pathology review, mammography alone detected 244 (65%) of the 374 minimal breast cancers confirmed. Historically, the detection of breast carcinoma while in its minimal state yields a 20-year survival rate of approximately 95%.

Based on the above information, it seems unfair and irresponsible to discourage sound, conscientious health habits on the basis of assumed risks. The technique of mammographic imaging is changing so rapidly that radiation doses in breast cancer screening have decreased over ten-fold in the past two years with prospects for a significant further reduction in the next year. Indeed, the absorbed dose to the breast midpoint is now so low that decision-making in regard to mammography need no longer include concern over radiation exposure. Using the radiation levels that are achievable today and linear extrapolation accepted by the most severe mammography critics, the estimated risk becomes a hypothetical figure of one induced breast cancer per ten million women screened. We physicians cannot address ourselves only to the predictions of a very small number of radiation-induced cancers in women in their later years of life. What we must consider is the great number of breast cancer deaths in women in their younger years—deaths that might possibly be prevented with the proper application of a proven diagnostic test.

JERRY B. BUCHANAN, M.D.
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Letters to the Editor

The Letters To The Editor column is a means for the KMA physicians to express their opinions and viewpoints on varied topics. If you have an item you would like brought before your fellow practitioners, please submit it to Letters To The Editor, Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Kentucky 40205. Communications should not exceed 250 words. The right to abstract or edit is reserved by the editors of *The Journal*. Names will be withheld upon request, but anonymous letters will not be accepted.

To the Editor:

July, 1976 marked the opening of the Highlands Baptist Hospital Oncology Unit. It was the logical answer to the demand for superior medical care and at the same time the need to provide psychological support. The Unit is designed to provide comprehensive care to the patient with malignant disease who is a candidate for chemotherapy. The purpose of this letter is to describe the operation of this facility and the benefits it has brought not only to patient care, but to the entire hospital.

From the outset, emphasis was placed on the coordination of ancillary hospital services to focus on the patient as a whole. Physicians, nurses, Social Service, Chaplain, Physical Therapy, Dietetics, and most recently, Occupational Therapy, function as a team to provide expert medical and psychological support to the patient and also his family. Daily rounds and weekly care coordination conferences are held. These services are routinely available for all patients on the Unit.

The approach of the nursing staff is of fundamental importance. Adequate staffing is essential. Using the primary care model, each patient is assigned a staff nurse who plans nursing care and who is responsible for its implementation. All nurses attend weekly in-service programs. These discussions provide background information in pathophysiology of the common malignancies. In addition, familiarity with chemotherapeutic agents, their actions, toxicities, and the mode of administration is expected.

No less important are nursing routines to permit early detection of infectious and hemorrhagic complications. The staff has learned to deal with emotional problems in suffering patients who are frequently in the terminal phase of illness. This is accomplished in a positive, sympathetic manner.

The hospital patient is evaluated by Physical Therapy. Preambulatory exercises, assistant devices, and attention to activities in daily living are emphasized. A new section of Occupational Therapy has been established in which each patient is evaluated for needs which, when met, will promote functional independence. Motivation to live and to function independently is the basic element toward which treatment is directed.

A full-time chaplain is assigned to the Unit. He provides psychological and religious support for our patients and staff. Family night programs, organization of volunteers, and supervision of student chaplains are included in his responsibilities. He is also available for counselling and outpatient follow-up.

Social Service plays an integral role in post-hospital planning. Referrals are made through community agencies, nursing facilities, transportation services, financial assistance programs, and other appropriate agencies. Home health care is coordinated by a nurse practitioner who works closely with Hospice volunteers, Unit volunteers and the Visiting Nurse Service. It is hoped that with proper support patients can be treated at home more effectively, particularly in the terminal phase of their illness.

The quality of patient care allows the implementation of complex treatment programs. For example, adult acute leukemia can be aggressively treated with confidence that therapy and its complications can be effectively managed. The American Red Cross pheresis facility adjoins the Unit and makes leukopheresis, and single donor platelet transfusion, available not only to our patients but to patients throughout the Louisville Regional Red Cross distribution area. Radiation therapy is accessible through the recently completed skyway to St. Anthony's Hospital. This is particularly advantageous to patients with painful bony lesions that cannot tolerate transportation by van or other vehicle.

The emotional stress experienced by all staff members has been significant. To date, no staff member has resigned because of inability to cope. Support systems are built individually between staff members, physicians and chaplains. Group support for the staff has been organized and will be led by a staff psychiatrist.

Patient acceptance of the concept of the Oncology Unit has been excellent. Interpatient relations have in general been good. Anxieties generated by admission to a "Cancer Ward" have been minimal. The advantages of coordinated care, coupled with knowledge that further hospitalization will be in familiar surroundings, with care by friends, are appreciated by patients and their families.

Hospital benefits from the Unit include new emphasis on innovative nursing care which has led to primary care nursing throughout the hospital. The Unit also was the impetus for the establishment of the Occupational Therapy Department, as well as Cancer Registry and an active cancer education program. Development of a pharmacy admixture program has been stimulated, and plans are being developed for special isolation facilities, outpatient treatment area, and expansion of home care support systems.

In the fall of 1978, a three-day conference devoted to major problems in Oncology will be offered. We expect to have periodic post-graduate education sessions for nurses, physicians and ministers. It is planned to expand participation in chemotherapy protocol studies. "Model"

home health care projects are planned. Elective rotations for students, house staff and fellows are anticipated.

What we have described is a beginning. Our early emphasis has been to promote quality medical and psychological patient support. We plan to expand our educational and research commitment. It is our hope that in the future, research and teaching will play a larger role in day-to-day function of the Unit.

The development of the Unit was aided by grants from the V.V. Cooke Foundation and the Gheens Foundation.

Charles Dobbs, M.D.
Manuel Grimaldi, M.D.
Ann Cox, B.S.R.N.
Oncology Unit
Highlands Baptist Hospital
Louisville, Kentucky

Blueprint of Change, continued from p. 446

This "consensus plan" embodies the principles set forth by the University administration and answers the majority of the concerns expressed by the faculty. Twelve of the 14 departments in the College elected by majority vote to accept the new plan and all but two of the full-time faculty in those departments have signed contracts accepting the new organization, thus indicating the breadth of overall approval by the faculty. Also, the new plan will more closely align UK with the national trends involving professional practice plans in medical schools across the country.

All of the above blueprints for change have given new hope and opportunities for the University of Kentucky College of Medicine, and its associated University Hospital, to grow to meet the educational needs of the Commonwealth; to continue to provide services for its people, and to advance medical knowledge and research in keeping with the aspirations and dreams of its founding fathers. While all problems have not been solved, the faculty and administration have found new avenues for working together in an effort to identify problems, quantify them, look at options and attempt to identify appropriate solutions.

★ ★ ★ ★

LOOKING AHEAD

September 24-28 KMA Annual Meeting, Hyatt Regency, Lexington

October 14 Regional Meeting, American College of Physicians, Lexington

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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ease see brief summary of prescribing information on facing page.

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If you've been prescribing pentobarbital or secobarbital for insomnia, there's good reason to reconsider.

More effective than secobarbital through 14 nights of administration...[1,2]

In two separate sleep laboratory studies,[1] secobarbital 100 mg was found to lose much of its initial hypnotic effect in insomniac subjects within a two-week administration period. Dalmane® (flurazepam HCl), however, has been proved[2] to remain effective for both inducing and maintaining sleep at the end of two weeks, with the usual adult dosage (30 mg *h.s.*). Elderly and debilitated patients should receive 15 mg initially, to help preclude oversedation, dizziness or ataxia.

And more effective than pentobarbital through 28 nights of administration...[3,4]

In an original study designed to evaluate hypnotic effectiveness for 28 consecutive nights of use, the relative ineffectiveness of pentobarbital was established after only two weeks.[3] Dalmane, however, remained effective not only for 14 nights, but for 28 nights in chronic insomniacs,[3,4] without increasing dosage from night to night. Prolonged administration of Dalmane is seldom necessary, but when it is, periodic blood counts and liver and kidney function tests should be performed.

More proven safety benefits for your patients than barbiturates...

Specific safety benefits not shared by barbiturate hypnotics: Dalmane (flurazepam HCl) may be used in patients on chronic warfarin therapy; no unacceptable fluctuation in prothrombin time has been reported.[5,6] And Dalmane has been proved not to interfere chemically with many common laboratory tests.[7-9] (Alterations have been reported due to pharmacological effects; see Adverse Reactions section of complete product information.)

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30-mg and 15-mg capsules

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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

References:

1. Kales A, *et al*: *Clin Pharmacol Ther 20*: 541-545, Nov 1976
2. Kales A, *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976
3. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
4. Dement WC, Guilleminault C, Zarcone V: Progress in clinical sleep research. Scientific exhibit at the American Medical Association, Atlantic City NJ, Jun 14-18, 1975
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6. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
7. Moore JD, Weissman L: *J Clin Pharmacol 16*:241-244, May-Jun 1976
8. Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
9. Kaplan SA, *et al*: *J Pharm Sci 62*:1932-1935, 1973

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Dr. Hoyt Gardner Talks To Kentucky's Physicians

The Journal recently interviewed Hoyt D. Gardner, a Louisville surgeon and Past President of KMA, who was voted President-Elect of the American Medical Association for 1978-79. Following are excerpts from that interview.

The Journal:

Since this is The Journal for Kentucky physicians, do you have a special message for them?

Doctor Gardner:

Yes, definitely I do, because without their help the victory wouldn't have been possible. It's always a lonely situation for a candidate, and without their enthusiastic endorsement, support and help—which couldn't have been better—we could not have won. It was just tremendous. Kentucky has always been known for its hospitality and its enthusiasm and appropriateness under occasions, and all of those things were exemplified to the utmost in this campaign; it's been proven by the results.

The Journal:

You said before the election that you want to return the Presidency of the American Medical Association to the membership. Do you see any significance in your election as part of a "grass roots" movement?

Dr. Gardner:

Yes, I think the Presidency has done an excellent job at large in speaking to the issues in front of external areas, but I think sometimes the members think the leadership of the American Medical Association is not in touch with the grass roots. I've head this repeated over and over in my journeys in other capacities. It seems to me that the time is appropriate and correct for the Presidency to be used to work with AMA, or "turn it back into the profession," I believe is the way I expressed it during the campaign, in order to touch the grass roots, and also to have the grass roots feel that they have an opportunity to hear from the leadership and can express themselves to the leadership. We need to communicate as intensely as we can, and we're doing it, as much as anybody knows how, and as expertly, as well. Personal interaction and interface with the Presidency, or whoever holds that office, is an important adjunct, I think now, to membership, to unity, and to communication. That was my commitment; to turn the Presidency back to the profession, the county and state associations, local and state reference committees, and to speak to the issues and to speak particularly to the strength of the American Medical Association—to tell how it's enlarged the profession and enhanced its quality and its excellence. Its accreditation, that is, the profession's, would not be possible without the American Medical Association.

All these things need to be said. The wonderful story of the American Medical Association needs to be understood first of all by our own people, our own physicians, and that being the case, my commitment is to make every effort to go every place they would want to hear the President speak, specifically in the profession—to the county and state associations."

Dr. Gardner addressing the AMA House of Delegates.

The Journal:

Then you plan to travel a great deal?

Dr. Gardner:

Well, the President always does. It's a matter of where he wants his priorities to be. It's a solemn commitment on my part to carry the Presidency back to the profession, or turn the Presidency inward, so to speak.

The Journal:

Was there any indication at the American Medical Association's meeting that your election is a tribute to the quality of "doctoring" in Kentucky?

Dr. Gardner:

The quality of "doctoring" is pretty homogeneous throughout the land. We here don't claim any special dimensions, although we do have two excellent medical schools, and we've always had an extraordinarily healthy medical community, both in Louisville and across the state. We've done a splendid job working with our allies, working with our other medical institutions, and our affiliated institutions, such as hospitals and paramedics. With all of these, our relationship generally has always been as good, if not superior, to any place, or anybody else. What this does is build a strength within the profession as well as gain support from its friends. It also builds an attitude of quality and excellence and confidence. All of these things, of course, emanate out when you enter into a campaign—that these are people who are committed, confident, competent, and supportive.

When you have these kinds of attitudes, people notice it, they see it and they respond to it. This is what people want—positiveness and support. And I'll say that people in Kentucky and Louisville have these qualities in the highest degree.

The Journal:

What about medical consumerism, or specifically, the so-called average person who receives medical care? Will you address this question early in your term of office?

Dr. Gardner:

We've always spoken to the best possible care of all people, within the abilities of their affordability. We always maintain quality control—by our medical audits, by our tissue committees, by our staff committees, and by the numerous other committees that serve our county societies and our state associations. All these are geared, for the most part, toward protecting the patients' interest. That includes the patients' help as far as educating them as to what is available and where to get it and if they have been treated justly, of course. This is consumerism. That's what it's all about. In comparison to many of the other sectors, we don't have anyone complaining particularly about our quality. The cost is a problem of inflation in every sector. There's no talk about lack of excellence of our research; nobody is condemning our medical schools or our accreditation process. There's no great condemnation of any of that. All this means that we have been doing a good job; that there is good consumer acceptance, and that we have been sensitive to these issues long before they became a public commodity or a public attention mechanism. Naturally, we continue to work at it and to enhance it. It's part of the profession; it's a part of the art and science, and of course, it's part of the commitment.

The Journal:

What about your practice for the next two years, Doctor?

Dr. Gardner:

I have to keep practicing. There's no way I can cease and desist that, but I think it does make a good point that a solo practitioner, in general surgery, is able to do this. Many of our people—physicians, I'm referring to, and I'd say also the auxiliary—say, "Well, I just don't have time to do those things." I would hope my election will show that it can be done, by anybody who wishes to prioritize their time and make a commitment. It's not impossible. Serving on the Board of Trustees is said to take between 60 and 80 days a year; they tell me the Presidency will require about 100 to 112 days a year, on the average. Of course that all varies by circumstance and things that happen, but that's not a whole lot more than I've already been doing and what I'm used to. The loyalty of my colleagues has made it possible for me to do this. I can't praise them strongly enough, for if they were not organizationally minded, and if they were not believers in having these things done, they would not have given me the coverage, and they wouldn't have referred their patients. It can be done; it's just a matter of making allowances for it in your life, and making the time.

KMA Executive Vice President, Robert G. Cox, escorts Dr. Gardner to the podium during AMA Annual Meeting.

The Journal:

This is your third interview today . . . on your day off, and I know you have had many others. Is there anything else you would like to say that hasn't already appeared in print?

Dr. Gardner:

Yes. A loud crescendo of thanks to Kentucky physicians! They have my deepest appreciation and gratitude. I know they are the ones who really won the campaign, and they're the ones who made it all possible. I've always said and feel sincerely, that ever since they first supported my candidacy for the Board of Trustees, this was Kentucky's seat on the Board of Trustees of the American Medical Association.

I feel the same way about the Presidency-elect and the Presidency. This is Kentucky's time, Kentucky's year, and Kentucky's opportunity. So I intend to work completely with my colleagues across the state of Kentucky to respond to the needs of the American Medical Association and of physicians everywhere. With my people's ideas, thoughts, efforts, expertise, knowledge, experience, and their help and support, I think it will be a great time for Kentucky's tenure in the Presidency.

Again, an individual can only do limited amounts. But with all of us banding together and working hard, as we have always done, I have no hesitancy in thinking we'll have a very successful Presidency, one of which we can all be proud and one that we can feel has been done well.

One more thing. Everyone is encouraged at the response by the medical students, interns and residents to the commitment that organized medicine is the best mechanism and vehicle to maintain quality and excellence and still be sensitive to patients' needs. They are joining in record numbers. Also, I encourage the Auxiliary to continue their activities and to enhance them, and to make increasing commitments, too.

This is all teamwork and community effort by physicians and their wives. It affects all our futures, so we'll all join hands together in a successful adventure, and venture, and we'll all look forward with great expectancy for this opportunity for service.

The Journal:

Thank you, Doctor Gardner.

ALL ROADS LEAD TO KMA's 1978 ANNUAL MEETING!

From the West on Bluegrass Parkway or Bluegrass Field (airport): Follow Versailles Road under New Circle Road to S. Forbes Road (Red Mile Road). Turn right on Forbes Road to Broadway. Turn left onto S. Broadway, stay left, turn left on High Street and immediately into Hyatt Regency entrance.

From the South on U.S. 27 (Nicholasville Rd.): Stay left, take New Circle Road West to Harrodsburg Road exit. Turn right and follow Harrodsburg Road (Broadway) to High Street. Turn left on High Street and immediately into Hyatt Regency entrance.

From the North or Northwest on I-75 and I-64: Take Exit 115 (Newtown Pike). Stay on Newtown Pike to W. Main Street. Turn left on West Main Street to Broadway. Turn right on Broadway one block to High Street. Turn right on High Street and immediately into Hyatt Regency entrance.

From the Northeast on I-64: Take Exit 113 (U.S. 27). Turn right onto Paris Pike (Broadway) and follow to High Street. Turn right on High Street and immediately into Hyatt Regency entrance.

From the Southeast on I-75: Take Exit 104 (Athens) to Richmond Road (U.S. 25). Turn left and follow Richmond Road through downtown. Stay left, turn left on South Broadway. Stay right, turn right on High Street and immediately into Hyatt Regency entrance

The Hyatt Regency Lexington Located Downtown at Lexington Center
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ASSOCIATIONAL NEWS

SCIENTIFIC SESSIONS WILL HIGHLIGHT 1978 KMA ANNUAL MEETING

The twin themes of "Pulmonary Disease" and "Endocrine Problems" will be discussed in the general scientific sessions of the KMA Annual Meeting on Tuesday, September 26, Wednesday, September 27, and Thursday, September 28, at the Hyatt Regency/Lexington Convention Center, Lexington.

The Meeting opens officially on Monday, September 25, when the House of Delegates meets at 9 a.m. in the Regency Ballroom of the Hyatt Regency. A second meeting of the House of Delegates will be held on Wednesday, September 27, at 6 p.m., also in the Regency Ballroom.

Twenty specialty groups will meet on Tuesday afternoon, September 26, and Thursday afternoon, September 28. Groups meeting Tuesday at 1:30 p.m. include anesthesiologists, chest physicians, emergency physicians, orthopaedists, pathologists, pediatricians, plastic and reconstructive surgeons, general surgeons, and urologists. Those meeting on Thursday afternoon at 1:30 p.m. are dermatologists, allergists and immunologists, family physicians, neurosurgeons, occupational physicians, obstetricians and gynecologists, psychiatrists, and public health physicians.

Governor Julian M. Carroll will be the featured speaker at the President's Luncheon, scheduled for 11:50 a.m. on Wednesday, September 27. In addition to Governor Carroll's address, there will be an awards ceremony and the installation of the KMA President, Carl Cooper, Jr., M.D.

Other events during this year's Annual Meeting include the KEMPAC Seminar, alumni reunions of the U of L and UK medical schools, and meetings of the Women's Auxiliary to KMA.

Complete details of the 1798 Annual Meeting appeared in the August *Journal* of KMA.

MISCELLANEOUS MEETINGS During 1978 Annual Meeting

Monday, September 25

9:00 a.m. KMA House of Delegates, Regency Ballroom, Hyatt Regency

12:30 p.m. Reference Committee Chairmen, Luncheon, Atlanta Room, Hyatt Regency

2:00 p.m. Reference Committee Meetings, Meeting Rooms A,B,C,D,E and F, Lexington Convention Center

6:00 p.m. KEMPAC Reception, Banquet and Seminar, Regency Ballroom, Hyatt Regency

6:00 p.m. Kentucky Urological Association, Social Hour, Washington and San Francisco Rooms, Hyatt Regency

Tuesday, September 26

9:30 a.m. Auxiliary Board Meeting, Regency Ballroom West, Hyatt Regency

12:00 noon KMA Executive Committee and Reference Committee Chairmen, Luncheon, Atlanta Room, Hyatt Regency

12:00 noon Kentucky Chapter, American College of Surgeons, Luncheon, Chicago and San Francisco Rooms, Hyatt Regency

5:00 p.m. U of L Alumni Reunion, Poolside, Hyatt Regency

5:30 p.m. Auxiliary Reception, Regency Ballroom Foyer, Hyatt Regency

6:30 p.m. Kentucky Chapter, American College of Pediatrics, Social Hour, Regency Ballroom West

6:30 p.m. Kentucky Urological Association, Dinner, Washington and San Francisco Rooms, Hyatt Regency

6:30 p.m. Kentucky Orthopaedic Society, Dinner, Regency Ballroom Center, Hyatt Regency

Wednesday, September 27

7:30 a.m. American Medical Women's Association, Atlanta Room, Hyatt Regency

8:30 a.m. Auxiliary County Presidents Breakfast

9:30 a.m. Auxiliary Meeting, Regency Ballroom West, Hyatt Regency

11:50 a.m. KMA President's Luncheon, Banquet Hall, Lexington Convention Center

3:00 p.m. KMA Board of Trustees Meeting and Dinner (5 p.m.), Hyatt Suite, Hyatt Regency

6:00 p.m. Second Meeting, KMA House of Delegates, Regency Ballroom, Hyatt Regency

Thursday, September 28

7:30 a.m. Kentucky Obstetrical and Gynecologic Society, Breakfast, Mary Todd Lincoln Room, Hyatt Regency

12:00 noon KMA Board of Trustees, Luncheon, Hyatt Suite, Hyatt Regency

12:00 noon Kentucky Obstetrical and Gynecologic Society, Luncheon, Regency Ballroom West, Hyatt Regency

12:00 noon Kentucky Occupational Medical Association, Luncheon, Washington Room, Hyatt Regency

12:00 noon Kentucky Psychiatric Association, Luncheon, Mary Todd Lincoln Room, Hyatt Regency

Reference Committee Activity

Speaker Bennett L. Crowder, II, M.D., Hopkinsville, will assign all officers' and committees' reports and resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9 a.m., Monday, September 25. **Briefing sessions** for Reference Committee Chairmen will be held at **12:30 p.m., Monday,** in the Mary Todd Lincoln Room of the Hyatt Regency Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the **Reference Committee meetings** which will be held at **2 p.m., Monday, September 25** at Lexington Convention Center, Meeting Rooms A through F. These open sessions will last one hour, in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final session of the House, Wednesday evening, September 27, in the Regency Ballroom, Hyatt Regency.

1978 KMA Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Meeting Room A

N. H. Talley, M.D., Princeton, Chairman
Donald R. Neel, M.D., Owensboro
Joseph H. Rapier, M.D., Prestonsburg
Carroll H. Robie, M.D., Louisville
Gene T. Watts, M.D., Hindman

REFERENCE COMMITTEE NO. 2

Meeting Room B

Allen E. Grimes, Jr., M.D., Lexington, Chairman
Keith E. Ellis, M.D., Benton
Paul J. Sides, M.D., Lancaster
Donald T. Varga, M.D., Louisville
Raymond D. Wells, M.D., Inez

REFERENCE COMMITTEE NO. 3

Meeting Room C

Charles C. Smith, M.D., Louisville, Chairman
Millard C. Loy, M.D., Columbia
Edwin J. Nighbert, M.D., Lexington
O. M. Patrick, M.D., Frankfort
James H. Simpson, M.D., Hopkinsville

REFERENCE COMMITTEE NO. 4

Meeting Room E

James A. Baumgarten, M.D., Owensboro, Chairman
Walter R. Brewer, M.D., Lexington
Glenn W. Bryant, M.D., Louisville
Don E. Cloys, M.D., Richmond
William R. Yates, M.D., Hebron

REFERENCE COMMITTEE NO. 5

Meeting Room D

William E. Becknell, M.D., Manchester, Chairman
E. Dean Canan, M.D., Louisville
Kenneth M. Eblen, M.D., Henderson
James C. Embry, M.D., Paducah
Ronald D. Hamilton, M.D., Lexington

REFERENCE COMMITTEE NO. 6

Meeting Room F

Cecil D. Martin, M.D., Carrollton, Chairman
Leslie W. Blakey, M.D., Lexington
James W. Forrester, M.D., Louisville
R. Gary Marquardt, M.D., Murray
R. D. Pitman, M.D., Williamsburg

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

AUGUST

9-10 Board of Trustees, Louisville
15 *Journal* Editors, Louisville
16 Judicial Council, Louisville

SEPTEMBER

4 Labor Day—Office Closed
7 Executive Committee, Louisville
Kentucky State Board of Medical Licensure, Louisville
Committee on Utilization Review, Louisville
12 *Journal* Editors, Louisville
13 Technical Advisory Council in Medical Assistance, Frankfort
14-16 AAMSE Board, Chicago
22-23 State Medical Advertising Bureau Annual Conference, Louisville
25-28 KMA ANNUAL MEETING, Lexington

Members in the news

NEW MEMBERS

CUMBERLAND
Samuel L. Rice, M.D., Burkesville

PIKE
Brent Brandon, M.D., Pikeville
Peter D. Goodwin, M.D., Cincinnati, Ohio

WARREN
Don Bui, M.D., Morgantown

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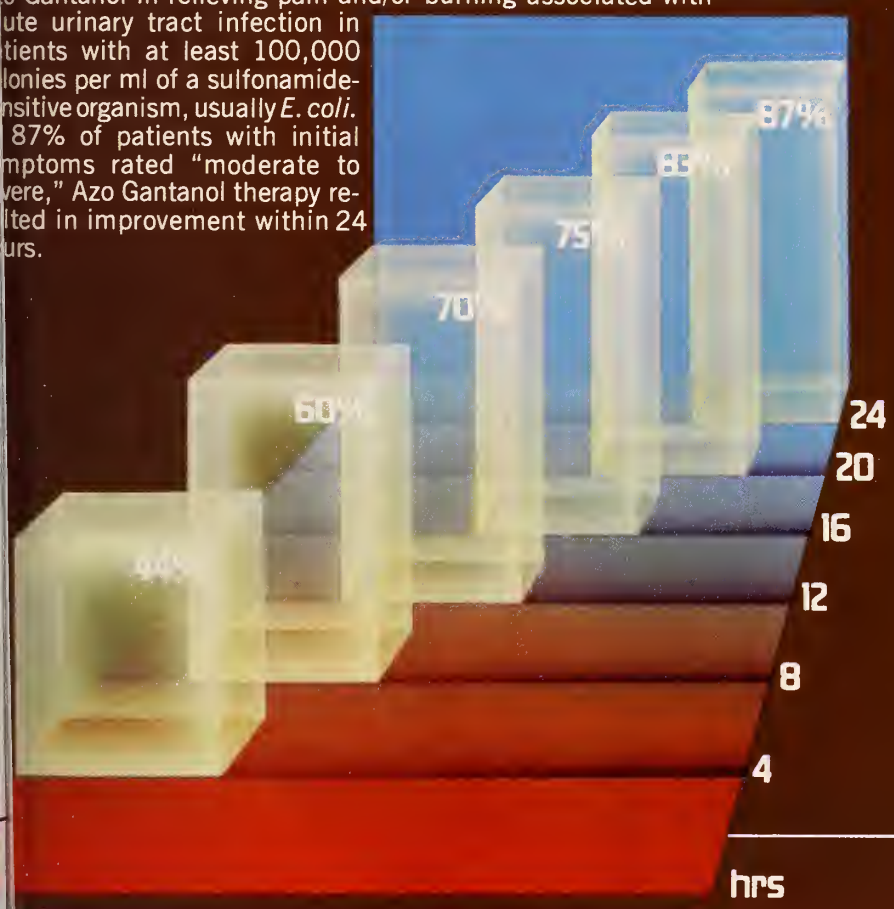

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on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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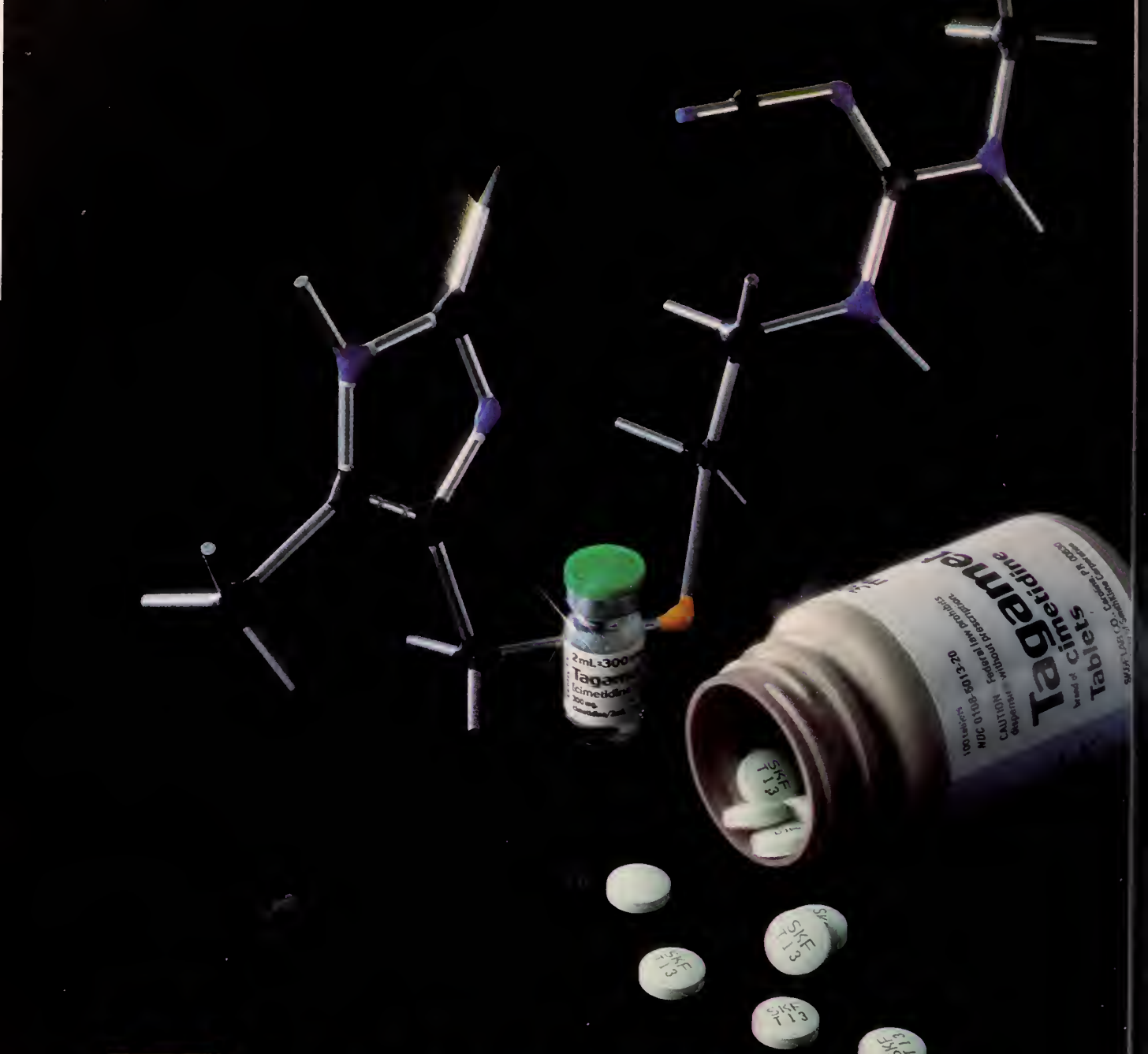
Nutley, New Jersey 07110



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brand of

cimetidine

How Supplied: Pale green, 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only).
Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

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a SmithKline company

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the most common complaint you'll see this winter?

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relief of minor sore throat when patients want it... *stat*

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TAT **mouthwash/gargle (and spray)** blends eugenol with l to provide a new authoritative flavor that tells your patients rom discomfort is at hand.

TAT **sore throat lozenges** combine menthol with phenol to e a desirable cooling action and anesthesia. These active ients are in a smooth-tasting sugar-free sorbitol base. The temporary relief and a smooth, comfortable taste.

STAT Products are now available for your mendation at pharmacies everywhere.

9A)

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Each tablet contains aspirin 227 mg; phenacetin, 162 mg, and caffeine, 32 mg, plus codeine phosphate in one of the following strengths: #4—60 mg (gr 1); #3—30 mg (gr ½); #2—15 mg (gr ¼); and #1—7.5 mg (gr ⅛). (Warning—may be habit forming)

CIII

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Make Plans Now

To Attend The Sixteenth

ANNUAL KEMPAC SEMINAR

Monday, September 25, 1978

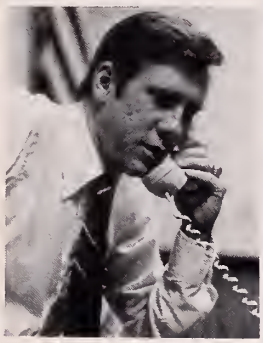
6:00 p.m. EDT — Reception

7:00 p.m.—Dinner with program to follow

Hyatt Regency Lexington Ballroom
Lexington, Kentucky

featuring

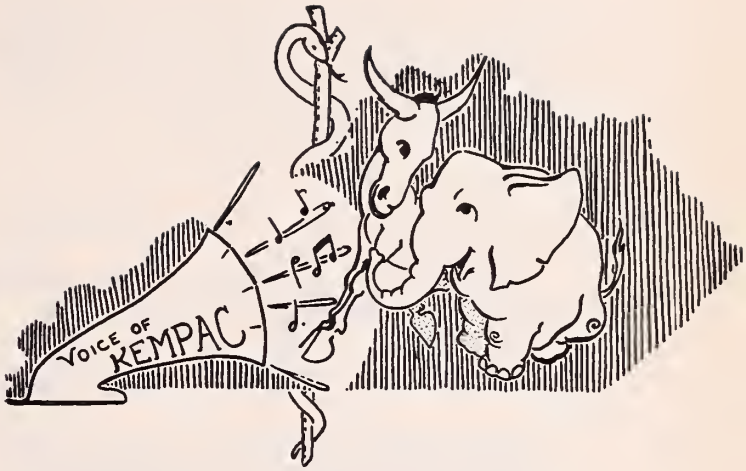
Walter "Dee" Huddleston
(D-Elizabethtown)



Louie Guenthner, Jr.
(R-Northfield)

Rex Kenyon, M.D.
AMPAC Chairman

The cost of each ticket is $15. Tickets can be purchased from a KEMPAC director, or by sending your check, payable to KEMPAC at 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.



KEMPAC IS

- A voluntary, non-profit group whose membership consists of physicians, their spouses, members of their immediate families and medical personnel. KEMPAC was founded in January, 1962, and exists to give the Kentucky physician an effective means of political action.

KEMPAC HAS

- 18 members, all appointed annually by the KMA Board of Trustees. There are 14 physicians, two from each congressional district, one from each major party. There are four members of the Auxiliary whose party affiliation is evenly divided from each major party. The major parties are the two parties that polled the greatest number of votes in the preceding presidential election.

KEMPAC DOES

- Consider all requests for funds from physician candidate support committees. Whether KEMPAC contributes to the candidate support committee depends upon many considerations. The support for candidates is based on realistic political appraisals. A KEMPAC member must have confidence in the chosen and elected Board of Directors and allow them, as a small and compact, well-informed group, to make decisions based upon all the facts.
- Encourage a member to give his political opinions, both vocal and in writing to the KEMPAC Board or the director in the respective area.

KEMPAC NEEDS

- The resources to effectively support candidates seeking election to the Kentucky Senate and House next year (100% of your membership contribution goes to candidate support).
- A greater awareness among the Kentucky doctors of the direct relationship between elections and medical legislation.
- Your interest and support.
- Your membership commitment now!

(See next page for membership information)

Complete this coupon; write your personal check payable to KEMPAC and mail to KEMPAC, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205, or give to the director in your area. If you are an Active member, consider becoming a Sustaining member.

Physician's Name Spouse's Name

Home Address

Please check the KEMPAC/AMPAC membership you desire.

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WE INVITE YOU TO STOP BY THE KEMPAC BOOTH WHILE YOU ARE ATTENDING THE KMA ANNUAL MEETING.

Copies of KEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from the Federal Election Commission, Washington, D.C. If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts or failure to make PAC contributions. Contributions are subject to the limitations of FEC Regulations, Section 110.1, 110.2 and 110.5. (Federal regulations require this notice).

In Memoriam

Frederick W. Wilt, M.D.
Georgetown
1903-1978

Frederick William Wilt, M.D., Georgetown, died on June 8. Doctor Wilt, a 1928 graduate of the University of Louisville School of Medicine, was in general practice and had served as Medical Consultant for Scott County Public Health Department. He was a member of the Kentucky Medical Association and the American Academy of General Practice.

Henry C. Cassini, M.D.
Louisville
1896-1978

Henry C. Cassini, M.D., died on August 15 at the age of 82. He was born in Orange, New Jersey and had been in general practice for 53 years. Doctor Cassini was a member of the Jefferson County Medical Society and the Kentucky Medical Association.

Did you know . . .

Hal E. Houston, M.D., a surgeon in Murray, Kentucky, has recently been elected chairman of the Jackson Purchase Area Health Education System (AHES). AHES is a program sponsored by the Council on Higher Education to create opportunities for off-campus health professional students and to solve the problem of health manpower distribution and effectiveness.

* * * * *

The University of Kentucky College of Medicine has received a grant of $303,870 to train an increased number of faculty in family practice. The funds, awarded by the Department of Health, Education and Welfare's Bureau of Health Manpower, will be distributed over a three-year period. The training programs will emphasize instructional, research and interpersonal skills to interested family physicians. Trainees will be selected from both established family practitioners and those who have only recently completed residency training in the specialty.

Number to Use for Messages is 606-233-4111

A Message Center will be set up during the 1978 KMA Annual Meeting. The telephone number where you may be reached is 606-233-4111. This is a central hotel number through which all messages will be routed.

The Message Center will be located inside the Convention Center at the mall entrance.

1978 KMA Annual Meeting Approved For Continuing Education Credit

The American Academy of Family Physicians has given approval for 18 hours of prescribed credit for this year's Annual Meeting.

Credit may also be obtained on an hour-for-hour basis toward Category I of the Physician's Recognition Award from the American Medical Association.

INFORMATION BOOTH
1978 KMA ANNUAL MEETING

The Auxiliary to KMA will staff the Information Booth, located next to the Message Center.

Medical Journal Ad
September, 1975
6 x 9—1-color
7 x 10—1-color

easy to take

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Help keep the mailing list up to date

JOB OPPORTUNITY PHYSICIAN

The Lake Cumberland Health Clinic, Inc., has an immediate opening for a Medical Director of an ambulatory care clinic in Russell County, located in South Central Kentucky. Russell County is blessed with Lake Cumberland, world-famous for fishing and boating. Salary, benefits and liability to be discussed. Project approved and funded under Rural Health Initiative grant. Project to be implemented as soon as physician desires. *Contact Eddie Girdler, P. O. Box 377, Jamestown, Kentucky 42629. Phone (502) 343-3154.* An Equal Opportunity Employer.

Emergency Department Staff Physician

Corbin, Ky., Monday-Thursday evenings; no days or weekends required. Stimulating variety of trauma and excellent backup; full Kentucky license required. Excellent income. ***Contact T. P. Cooper, M.D., 1-800-325-3982, or send CV to 970 Executive Parkway, St. Louis, Mo. 63141.***

Mark Your Calendar

for

1978 KMA Annual Meeting

September 26-28

Hyatt Regency/Lexington Center

Lexington, Kentucky

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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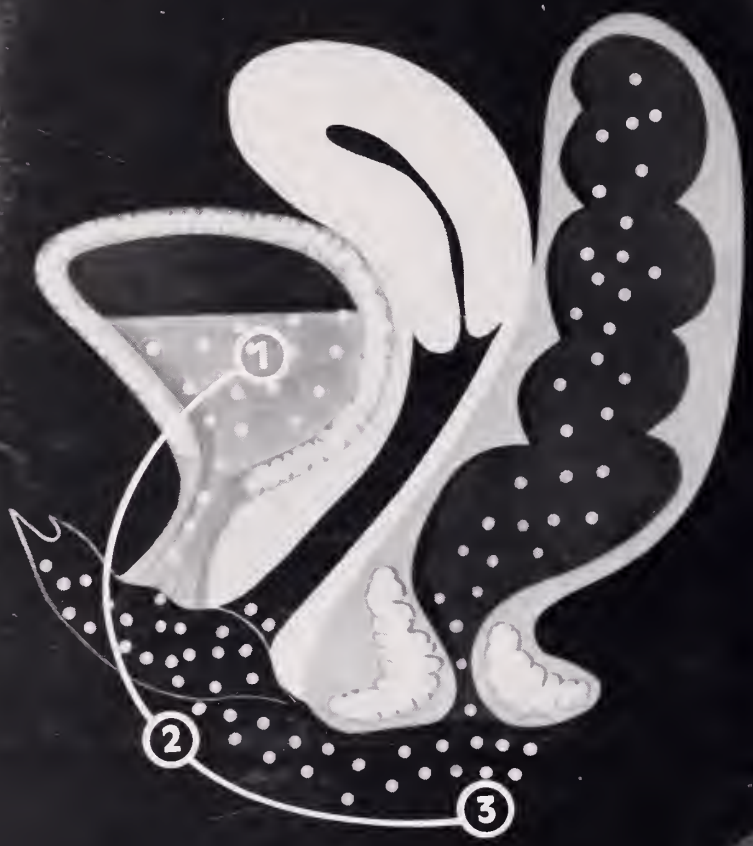
Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introitus colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

October 1978
Volume 76
Number 10

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CARL COOPER, JR., M.D.
KMA PRESIDENT
1978-79

The Journal Of The Kentucky Medical Association

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THE MESSAGE OF TENSION

HEADACHES
SWEATS
TENSE, TAUT MUSCLES
HYPERVENTILATION
TACHYCARDIA
PALPITATIONS
BURNING IN STOMACH
FULLNESS
FREQUENCY

to relieve psychic tension and its functional symptoms

VALIUM®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the indi-

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predispos-
tion to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Volume 76 • October 1978

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MESSAGE FROM THE PRESIDENT

THIS article is being written prior to our Annual Meeting in Lexington, but will not appear in *The Journal* until after the meeting.

I feel that I might better express some of my objectives and considerations for the coming year if the meeting had been concluded, but that is not the case, so here are a few thoughts.

My primary emphasis will be on the cost of medical care, and especially on the Voluntary Effort, which will coincide with the program outlined by Doctor Tom Nesbitt, President of AMA.

I feel that we in Kentucky can and will meet the challenge of holding down medical care costs and hopefully can assist others in the health care field. This is very important, but not as important as quality health care and this must not be sacrificed to meet a goal. The success of our efforts will depend a great deal upon our patients' needs and demands, as well as the control of inflationary trends by our suppliers of drugs and equipment.

Thus far, we have avoided a mandatory cap on hospital and medical care and this can only continue if we meet the challenge. Each of us must give full consideration to our individual effort and not be too concerned what the other fellow is doing.

We must prevent the government's intervention into health care at every point if we are to hold the tide of rising costs. All of us know that each new plan or program ultimately decreases the effectiveness of medical care and increases the cost.

I would also again urge all of you to get involved in local and state-wide politics. Support your candidate and get to know him. Encourage him to support medicine and show him we are interested in our patients and good medical care, rather than our "pocketbooks."

I am looking forward to seeing most of you in Lexington and feel sure this will be a most outstanding meeting.

A special thanks to Fayette County Medical Society for its hospitality.

CARL COOPER, JR., M.D.
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Eczema (dermatitis)—Classification, Diagnosis, and Treatment

Jeffrey P. Callen, M.D., and Lafayette G. Owen, M.D.

Louisville, Kentucky

The term eczema (dermatitis) is derived from Greek meaning "to boil." This group of conditions is characterized by two clinical presentations which depend on the duration and intensity of the reaction (acute vs chronic). Eczema is an inflammatory condition which in the acute phase is characterized by blister formation and in the chronic phase by lichenification (thickening of the skin with increased skin markings). Once a diagnosis of eczema is made, careful investigation must be conducted to determine an etiology before appropriate therapy may be given. The purpose of this paper is to review the classification, diagnosis and treatment of this common skin reaction pattern.[1]

THE eczemas may be divided into at least five groups (Figure 1). Without separation of these entities, appropriate investigation and therapy cannot be accomplished.

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Received at KMA 6-2-78

Atopic Dermatitis

Atopic dermatitis is a specific disease process which may or may not occur in conjunction with other atopic disorders (allergic rhinitis or hay fever; extrinsic asthma) (Figure 2). The diagnosis of atopic dermatitis cannot be made with one simple clinical or laboratory test. In atopic dermatitis, the eruption characteristically involves the antecubital and popliteal fossa and the sides of the neck. Recently, Hanifin and Lobitz have suggested a set of criteria to establish the diagnosis of atopic dermatitis[6] (Table 1). These criteria are helpful clinically, but more importantly, may allow investigations based on a uniform group of patients.

Atopic dermatitis occurs in three forms: 1) infantile, 2) childhood, and 3) adulthood. In most instances it is associated with atopy in the individual or other family members. In infancy the eruption is generally symmetrical and most commonly involves the face (cheeks), extensors surfaces of the extremities, and the diaper area. The rash is poorly demarcated erythematous plaques and papules with some scaliness and lichenification. In blacks the rash tends to be more papular. Many of the patients with infantile eczema (probably 50%) will spontaneously clear between two and three years of age.

Childhood eczema generally involves the flexural areas (Figure 3). Pruritus becomes a major complaint. Dramatic lichenification (thickening of the skin—increased skin markings) is almost always present. Not uncommonly an "atopic" salute is seen in these patients, characterized by a horizontal fold of the skin just above

Table 1

CRITERIA FOR DIAGNOSIS OF ATOPIC DERMATITIS (DERIVED FROM HANIFIN & LOBITZ)

Constant Features

1. Pruritus
2. Typical morphology (see text)
3. Chronicity

Variable Features

1. History of atopy (patient or family)
2. Immediate skin test reactivity
3. White dermatographism
4. Anterior subcapsular cataracts
5. Xerosis
6. Pityriasis alba
7. Keratosis piliaris
8. Infraorbital fold
9. Keratoconus
10. Elevated serum—IgE
11. Tendency to hand dermatitis (see section on dyshidrotic eczema)
12. Repeated cutaneous infections

the nose; this probably reflects the presence of allergic rhinitis. Also, infra-orbital folds have been described to be associated. The eczematous eruption is a cosmetic as well as a medical problem and school adjustments may be difficult. Although childhood onset atopic dermatitis may clear in adolescence or early adulthood, many cases persist throughout life. Generally there is no scarring or residual. However, if there has been impetiginization (secondary infection), scarring may occur, or if the patient is black, secondary pigmentary changes may occur. Early vigorous treatment may minimize the likelihood of chronicity.

When atopic dermatitis appears in adolescence or adulthood it may be more persistent. It most commonly is symmetrical, and flexural areas have a propensity to develop the rash. Also hand, foot, or eyelid problems may be a major feature of this disorder. Pruritus is again a major component.

In all forms of atopic dermatitis there are no laboratory tests which can confirm the diagnosis. Histological examination reveals a reaction pattern which is indicative only of dermatitis (eczema). The only test which may be useful is an IgE level, which tends to be elevated in patients with atopic dermatitis. However, there is not a good correlation with level and severity of disease. Also patients may have typical atopic dermatitis with normal IgE levels.

Atopic dermatitis is associated with at least four other problems. Asthma (extrinsic) and hay fever commonly accompany eczema (50-60%).[7] These are actually part of the disease spectrum as outlined in Table 2 and Figure 2, and are not complicating conditions. Cataracts occur in a small percentage of patients, and are peculiar since their location is central, and the occurrence is in early adulthood. Although cataracts may occur in association with the disease, they also occasionally complicate the therapy (corticosteroids). Keratoconus (thickening of the cornea) may also occur, particularly in those patients with eye involvement. Pityriasis alba, or patchy hypopigmented areas on the cheeks and upper trunk, occurs in children with familial atopy as well as those with atopic dermatitis (Figure 7). Keratosis pilaris (small keratotic papules usually on the proximal extremities) are also quite commonly seen in atopy. Severe xerosis, or mild ichthyosis simplex, is also occasionally associated with atopic dermatitis.

Table 2

FACTORS WHICH MAY EXACERBATE ATOPIC ECZEMA

1. Dryness—frequent bathing, decrease in humidity
2. Infections
3. Clothing
4. Diet
5. Emotional Aspects

Atopic dermatitis is quite commonly complicated by bacterial infections, particularly staphyloccoccal. It may also be complicated by viral infections, particularly vaccinia or herpes simplex virus. These may become generalized in patients with atopic dermatitis. When associated with a vaccination, the term eczema vaccinatum has been applied; when associated with herpes simplex, eczema herpeticum.

The differential diagnosis of atopic dermatitis generally is not difficult. In infancy seborrheic eczema cannot be separated with any certainty.

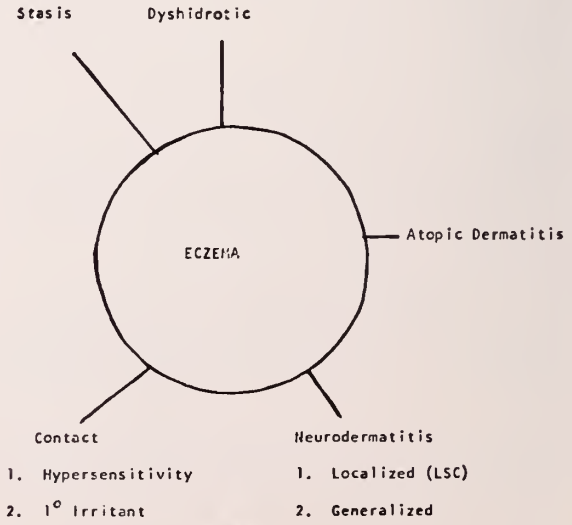

Figure 1. Spectrum of Eczema

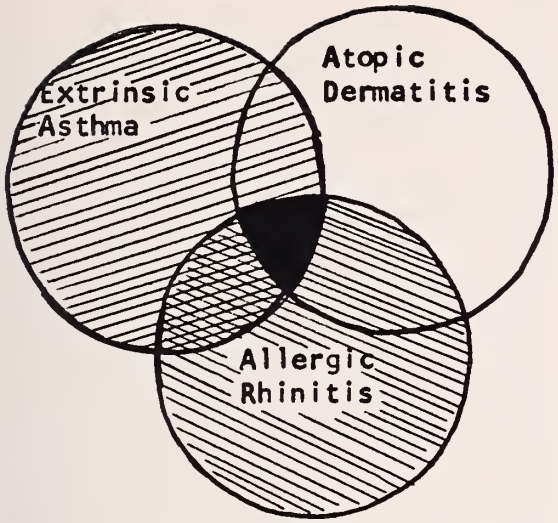

Figure 2. Atopy—overlap of processes

In childhood the picture is usually quite characteristic. However, in adulthood the problem is clouded again. Atopic eczema of the hands and feet may appear clinically, similar to dermatophyte infections, psoriasis, or other types of eczema. The generalized type may appear similar to generalized neurodermatitis.

The etiology and pathogenesis of this disorder are poorly worked out, and a discussion of these is beyond the scope of this article. The reader is referred to two excellent reviews of this problem.[3,6]

Treatment of severe atopic dermatitis is one of the great challenges of medicine. The most important facet of the care of these patients is to remove any and all factors which exacerbate the process. Also, care must be taken, particularly in infants and children, that the patient does not develop any long-term side effects from the therapy.

Factors which will exacerbate atopic eczema are listed in Table 2. **Dryness** of the skin in these patients is the most important factor seen on a daily basis. Dryness is caused by excessive evaporation of fluid from the stratum corneum. This is exaggerated by frequent bathing of the atopic skin. It is not uncommon to discover that the eczema patients bathes one or two times per day. Also, as the outside air temperature drops, the inside humidity becomes very low and may cause marked evaporation of water from the skin. This accounts for the exacerbations seen during the fall and winter months in many patients. It is, therefore, wise to have the patient bathe less frequently, take lukewarm baths, use bath oil, and apply lubrication following baths. **Infection** of the skin will certainly complicate the process and some physicians feel that it may be an initiating factor. This remains a controversial subject; however, occasional patients will clear with systemic antibiotics used for other reasons. **Rough** clothing has been reported to exacerbate the process, but in our experience it has not been of benefit to change this aspect of the patient's life except for the avoidance of course wool fibers. Although **diet** occasionally may be important in infantile eczema, it does not seem important in adult or childhood forms except in rare cases. A practical approach or removal of the offending food(s) is wiser than a restrictive diet. Lastly, **emotions** definitely seem to be active in the disease. However, whether the emotional disturbance is due to the disease or the disease is due to the emotions cannot be well worked out. Only rarely have tranquilizers seemed to be of benefit in practice.

Since eczemas are inflammatory conditions, anti-inflammatory agents are helpful. Various forms of irradiation are anti-inflammatory. Superficial x-ray was used by dermatologists for many

Figure 3. Atopic Dermatitis—typical flexural distribution with excoriations and lichenification (thickening) on the skin

Figure 4. Pityriasis alba

Table 3

MOST COMMON CAUSES OF CONTACT DERMATITIS

1.	Rhus	(poison ivy, oak, sumac)
2.	Paraphenylenediamine	(hair dyes, ink, x-ray fluids)
3.	Nickel	(metals)
4.	Rubber compounds	(elasic, rubber)
5.	Ethylenediamine	(aminophylline, dyes, rubber, waxes, mycolog® cream, some antihistamines)

years before the long term dangers became apparent. Sunlight, ultraviolet light, and grenz ray are safe but beneficial forms of irradiation. Tars have been used for their anti-inflammatory effect for many years. Today the most potent anti-inflammatory agents are steroids. They are used topically except in severe cases and are available in creams, ointments and lotions. They may be combined with tars to enhance their efficiency.

After examining and removing or altering the exacerbating factors, attention can be paid to further therapy—the cornerstone of which is corticosteroids. Many cases will respond to mild agents such as a 1% hydrocortisone cream, which has few side effects. In those patients who do not respond, more potent corticosteroids are indicated (triamcinolone, fluocinonide, betamethasone). However, these agents may cause atrophy with long term use, particularly when used with occlusive dressings. If the patient does not seem to respond to these local measures, systemic therapy is indicated. The use of antipruritics (Periactin^R, Temaril^R, Benadryl^R, Atarax^R, etc) is very important. These drugs should be used to the tolerance of the patient; in other words, if there is pruritus but the patient has no side effects from the drug chosen, the dosage may be increased. The most frequent side effect is drowsiness. If the patient requires additional therapy, systemic corticosteroids may be used either orally or intramuscularly. Systemic corticosteroids are generally given for short periods of time to control acute flares.

Lastly, the therapy of atopic eczema may be complicated by the therapy of other atopic disorders in the same individual. The question of immunotherapy (hyposensitization) in atopic dermatitis is highly controversial. Atopic patients may show positive intradermal reactions to a variety of substances which clinically are inconsequential. Furthermore, in some cases hyposensitization has seemed to exacerbate the cutaneous disease.

Contact Dermatitis

Contact dermatitis[11] is an eczematous reaction pattern caused by a chemical which comes in "contact" with the surface of the skin. The reaction may be either a primary irritant or a hypersensitivity reaction. The hypersensitivity reaction is a cell-mediated, or immune phenomenon, occurring in the upper dermis. Any substance is a potential cause of contact dermatitis. The reaction does not develop on the first exposure. A model used to test immunocompetency has been the development of contact dermatitis with dinitrochlorobenzene (DNCB). Most important in the problem of hypersensitivity contact dermatitis is the separation from a primary **irritant dermatitis.** Irritants damage the skin by a toxic or irritant action, and will cause damage in most people if the exposure is appropriate.

Contact dermatitis is recognized by its unusual pattern of reaction. The skin reaction is definitely eczematous; however, the **distribution** is often the key feature. Multiple reaction patterns exist; it is impossible to enumerate them all, but we will attempt to discuss some of the common patterns. The five most common causes of contact dermatitis are listed in Table 3.

One of the most commonly encountered contact dermatitis is caused by poison ivy, oak, or sumac. The reaction patterns to all of the rhus plants are similar. Linear areas of pruritic vesiculated skin is common on exposed surfaces (Figure 5). In addition, the oil of the plant may be transported to other areas of the body and reactions around the eyes or genitals are commonly seen. The intensity of the dermatitis depends on the individual's sensitivity and the intensity of the exposure. Once a sensitive individual has been exposed, careful washing is advised to prevent spread of the oil (pentadecylcatechol) to other areas. The blister fluid does **not** contain any appreciable amounts of oil and is **not** allergenic. Rhus dermatitis is **not** passed from one individual to another except in very rare instances.

Rhus dermatitis is a self-limited acute contact dermatitis. Supportive therapy often is all that may be necessary. However, many cases will last 10-20 days with late vesiculation in less exposed areas; therefore, early suppressive therapy has been advocated. Supportive therapy includes symptomatic relief of pruritus, local soaks with tap water or Burow's^R solution, and applications

of moderately strong corticosteroid creams (triamcinolone, betamethasone, etc). Patients with minimal exposure will do well with these procedures. Administration of systemic corticosteroids will generally suppress the reaction to the poison ivy plants. Oral steroids (Prednisone) or intramuscular steroids (Kenalog^{R}) may be useful. The dose must be sufficient to suppress the reaction, and it must be sustained long enough to suppress the late reaction. When Prednisone is used, an initial dose of 40-60 mg per day is required, with a taper period of 10-14 days. When intramuscular steroids (triamcinolone) are used, 60-80 mg is necessary, with a repeat IM dose of 30-40 mg in five to seven days. In general, these therapies are safe and without long term side effects. Some water retention may occur, but this is quickly reversible when the steroids are discontinued. Glucose intolerance is generally not a problem except in patients with diabetes, and in these patients **caution** is advised. In patients with recurrent severe attacks, recognition and avoidance of the plant is strongly advised.

Nickel dermatitis is a common problem, and is often diagnosed by the patient. The reaction occurs where contact of the skin is made with metal containing nickel. Almost all jewelry contains trace amounts of nickel; however, in 18K gold, and stainless steel, the nickel is less accessible; therefore, patients may be able to wear jewelry made with these metals. Nickel is also found in belt buckles, glasses, metal buttons and in shoes. Hypersensitivity to nickel is a common problem after ear piercing, and may mimick a superficial infection of the earlobes (Figure 6). Treatment of nickel dermatitis requires recognition and prevention. The reaction is usually suppressed with topical corticosteroids. Avoidance is not difficult once the patient recognizes that metal is the cause of the problem. The metal object (such as an earring) can be sprayed with Kenalog^{R} prior to being worn.

Rubber dermatitis is due to the stabilizers or oxidants used in the preparation of rubber. The rash is generally recognized around the elastic waist band of underwear in men (Figure 7) and other elastic garments in women. Rubber may also be the cause of many shoe dermatitis reactions, since rubber cement is commonly used in most shoes. The treatment is similar to that of nickel dermatitis—recognition, topical agents, and avoidance.

Figure 5. Rhus dermatitis demonstrating linear vesiculation

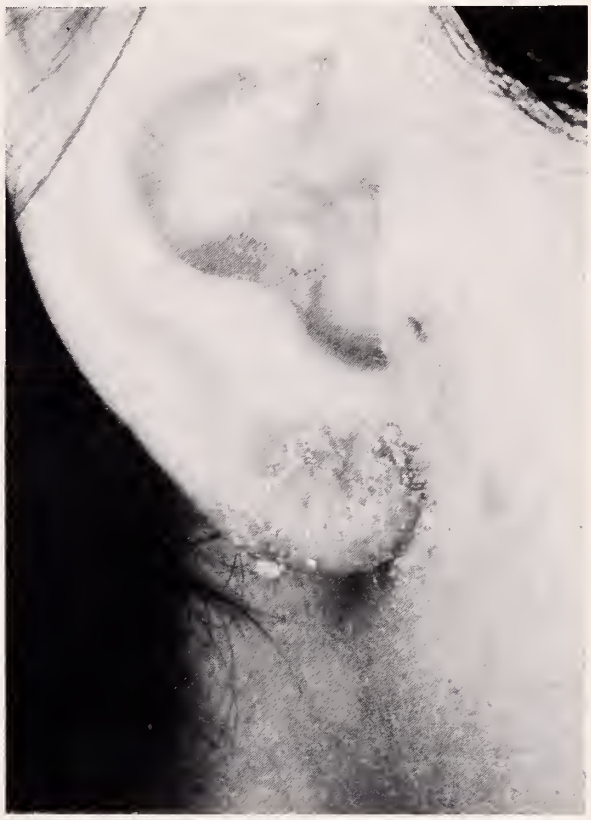

Figure 6. Nickel dermatitis on the earlobes following ear piercing

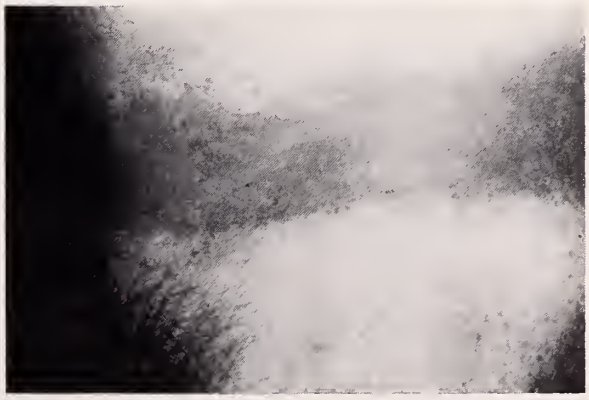

Figure 7. Rubber dermatitis secondary to an elastic band in underwear

Figure 8. Typical lesions of hand eczema (dyshidrosis)

Figure 9. Lichen simplex chronicus

Cosmetics are widely used in our society. Reactions to these are commonly talked about, but rarely occur. Cosmetic dermatitis represents less than 1% of the contact dermatitis in our practice. Generally the patient becomes aware of the problem, and may change cosmetics.

The diagnosis of contact dermatitis may not be obvious when dealing with reaction patterns which involve the hands, feet, scalp or trunk. The physician should be suspicious that contact reactions may be occurring in any patient with chronic recalcitrant dermatitis. Patch tests are most helpful in industrial cases of hand dermatitis, and shoe dermatitis, but may also be helpful in patients with eczema of unknown cause. In these patients "allergy" tests should be carried out. This testing involves an attempt to induce the contact reaction in a small area (patch) on the back or upper forearm. Appropriate concentrations of test material are defined by the North American Patch Test Group. Raw materials should not be used in full strength as they may produce an irritant reaction. The testing and reading of patch tests is generally best performed by an experienced physician. Patch tests cannot be done during active dermatitis because of false positive results, or in patients on high dose corticosteroids because of false negative results. If a material is found to be reactive, then it must be identified in the contactants of the patient or among substances which might cross-react with their material.

Hand Eczema (Dyshidrosis)

Hand eczema is a chronic recurring condition of dermatitis on the hands. It is generally a primary irritant reaction, but may rarely be caused by hypersensitivity reactions. It is a common problem, affecting between one-half percent of the "normal" population in some degree, and therefore comprises a large percentage of a dermatology practice. This condition is more common in atopic individuals and in individuals with hyperhidrosis or "sensitive skin."

The rash is manifest by vesiculation and intense pruritus, usually involving the lateral aspects of the fingers initially (Figure 8). The palms and dorsum of the hand may also be involved. The reaction has spontaneous remissions and exacerbations. Stress, both emotional and physical, chemical irritants, and dry, cold weather often will be initiating factors. Frequently, excessive hand washing will exacerbate the problem.

The differential diagnosis includes hypersensitivity contact dermatitis, fungal infections and psoriasis. In general, contact dermatitis is difficult to rule out without patch tests; therefore, in almost all patients with chronic hand eczema, patch testing is strongly advised. This is particularly helpful in industrial cases. Fungal infections may produce a similar rash on the hands, but it is more often unilateral, accompanied by foot involvement, and is far less pruritic. Fungal infection can be ruled out by a KOH (potassium hydroxide) preparation and a fungal culture. Psoriasis may be identical to hand eczema; therefore, each patient should be questioned about family and personal history of psoriasis and atopy. Examination for other features of psoriasis and eczema should be made. At times only the course of the rash will make the appropriate diagnoses.

Treatment of hand eczema is generally not difficult. Measures to remove exacerbating factors such as stress, xerosis (dryness), irritants,

and excessive hand washing will be very helpful. Lubrication is very important. Topical corticosteroids are generally sufficient to control the disease, but in severe cases, or in patients with acute exacerbations, systemic corticosteroids may be necessary. Antipruritics are indicated for symptomatic benefit. In Caucasian patients the judicious use of grenz ray (superficial type of irradiation) may allow steroid sparing.

"Neuro" Dermatitis

"Neuro" dermatitis is a misnomer, since it refers to an unproven connection between the skin and the nervous system. The condition is characterized by a localized easily recognizable form (lichen simplex chronicus) and more generalized forms.

Lichen simplex chronicus is a chronic rash in which a localized area of skin has severe lichenification (Figure 9). Generally there are also excoriations present. This condition is not uncommon and will characteristically present on the anterior leg of women, or the posterior neck in men. Its treatment is conservative, with local lubrication, topical corticosteroids, and systemic antipruritics.

The more generalized form represents a medical therapeutic challenge. This condition must be differentiated from infestations (scabies) and dermatitis herpetiformis (a symmetrical excoriated vesiculobullous disorder). Its treatment consists of antipruritics, lubrication, mild topical corticosteroids, and counseling patients to the awareness that they cause their own rash.

Stasis Dermatitis

Stasis dermatitis is an eczematous eruption on the lower legs occurring in a patient with chronic or acute edema. The eruption generally demonstrates scale, crusting, and lichenification in chronic cases, but may show bullae in acute forms. Many times topical agents have been used by the patient and careful evaluation to rule out contact dermatitis is necessary. The problem may be exacerbated by other factors such as xerosis, irritants, etc as in other forms of eczema. Meticulous topical care is required, and in addition, removal of edema is important in preventing recurrences. Antipruritics and systemic corticorsteroids are of less value in this condition. Caution must be advised in the use of systemic corticosteroids which may induce salt retention, and increase the edema.

Acknowledgement

The authors gratefully acknowledge Doctor Fernando Botero for providing Figures 5 and 9.

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Abdominal Aortic Aneurysm in Marfan's Syndrome

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Murray, Kentucky

A 23-year-old male with the stigmata of Marfan's syndrome was explored, with the diagnosis of traumatic abdominal aortic aneurysm which was found to be secondary to cystic medial necrosis. This represents the sixth reported case of Marfan's syndrome with abdominal aortic aneurysm and the third case successfully resected.

Introduction

ALTHOUGH the association of dissecting thoracic aortic aneurysms and Marfan's syndrome[1] (arachnodactyl) is well known, an abdominal aortic aneurysm in this syndrome is extremely rare. In an extensive review of the literature, Hirst et al[2] and Gore and Hirst[3] found aneurysms of the abdominal aorta to comprise only about four percent of all dissecting aneurysms. Although dissecting aneurysms in patients under the age of 40 are uncommon in patients with Marfan's syndrome,[4] they have been reported in children.[5-7] A ruptured thoracic aortic aneurysm was reported in a four-year-old with Marfan's syndrome.[8] There have been only five reported cases[9-13] of abdominal aortic aneurysm and Marfan's syndrome. Mouran et al[9] reported one in a 64-year-old patient and Langeron et al[10] reported one in a 27-year-old, neither of whom was operated upon. Hardin and Creighton[11,12] reported a 21-year-old patient with a ruptured abdominal aortic aneurysm who died during surgery, and a 46-year-old patient without rupture who underwent successful repair with a graft. Yu[3] successfully resected an abdominal aortic aneurysm in a 21-year-old patient who had undergone surgery for a spontaneous pneumothorax two months before. All five of these cases were in males, as is the present case which represents the third successfully repaired.

From Houston-McDevitt Clinic, Murray, Kentucky, and the General Surgery Department, University of Louisville School of Medicine, Louisville, Kentucky.

Report of a Case

A 23-year-old male was admitted to the hospital because of a 15 pound weight loss and abdominal pain of one month's duration. He stated that a fall on his left side one month previously seemed to initiate the pain. He had suffered from asthma as a child and had worn glasses for myopia for several years, but there was no family history of similar problems. Examination revealed a tall, thin individual with sunken eyes, narrow face, long spindly fingers, and a pigeon breast (pectus carinatum). Eye examination revealed myopia only without lens dislocation. There was no heart murmur. There was a 10 cm tender, pulsating mass in the right midabdomen.

A trans-femoral aortogram demonstrated an abdominal aortic aneurysm arising just distal to the renal arteries and extending to the aortic bifurcation. Both true and false channels were believed to be present. Laboratory data included normal serum cholesterol and lipid studies.

The patient was operated upon and found to have an abdominal aortic aneurysm extending from just below the renal vessels to the aortic bifurcation. The lumen was opened, and a large organized thrombus was noted to be attached to most of the posterior wall. There was no atherosclerosis and no intimal tear or re-entry point could be found. Pathological examination of a portion of the sac revealed cystic medial necrosis, with irregularity and fraying of the elastic fibers consistent with the diagnosis of Marfan's syndrome. The patient recovered uneventfully and returned to his job within three weeks.

Discussion

Patients with Marfan's syndrome characteristically have abnormalities of the ocular, skeletal and cardiovascular systems. This patient did have myopia, but the usual subluxation or dislocation of the lens was not present. His skeletal findings consisted of pectus carinatum and long, spidery fingers. The usual cardiovascular components of the syndrome include various cardiac defects with atrial septal defects being the most common. Ventricular septal defects and tetralogy of Fallot are

occasionally seen. Dissecting aneurysms of the thoracic aorta are the commonest cause of death. In this patient the abdominal aortic aneurysm was thought at first to be on a traumatic basis because of the patient's age and history, as well as the rarity of this lesion. However, the findings at operation and the pathological examination revealed the aneurysm to be the result of cystic medial necrosis without dissection.

Acknowledgement

The author thanks Dr. Allan Lansing in Louisville, Kentucky for his assistance in preparing this manuscript.

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Acquired Non-Malignant Broncho-Esophageal Fistula: Report of a Case

Sibu P. Saha, M.D., Porter Mayo, M.D., Gordon L. Hyde, M.D., and Richard F. Hench, M.D.

Lexington, Kentucky

A case of acquired benign esophago-respiratory fistula due to esophageal diverticulum is presented. The patient was treated successfully with surgical repair after multiple failures with non-operative treatment. This is a rare clinical entity. The prognosis is good. However, early diagnosis and prompt repair is necessary to prevent serious pulmonary complications.

BRONCHO-ESOPHAGEAL fistula, secondary to a ruptured mid-esophageal diverticulum, is extremely rare. Wychulis[1] et al found only four such cases in their review of 36 patients with acquired nonmalignant esophago-tracheobronchial fistula. In this report we present one such patient successfully treated by operation.

Report of a Case

A 79-year-old woman was hospitalized with progressive dysphagia and recurrent respiratory tract infection. Physical examination revealed a chronically ill woman who showed signs of recent weight loss. She weighed 80 pounds at the time of examination. Past history revealed a history of nephrectomy in 1948, cerebrovascular accident about three years earlier with good recovery, and hypertensive cardiovascular disease with normal blood pressure at the time of examination. An endoscopic examination of the esophagus and tracheo-bronchial tree failed to show any evidence of tumor. A barium swallow showed a mid-esophageal diverticulum communicating with the right bronchial tree (Figure). The patient's general condition improved with treatment; namely, antibiotics and nourishment provided through a nasogastric tube. A barium swallow at the time of discharge showed that the fistula tract had healed completely.

About two weeks following discharge, the patient had recurrent symptoms and a repeat barium swallow confirmed re-opening of the fistula. At this time a gastrostomy was performed to provide nutrition. A direct surgical approach for the repair of fistula was discussed, but not performed, because of the poor general condition of the patient. During this hospitalization she had another episode of stroke and was left with a slight residual paralysis of the right foot. Even so, she recovered fully from this episode and was gaining weight on gastrostomy feeding. About four months following this episode, a barium swallow was performed which showed no evidence of fistula; therefore, the gastrostomy tube was removed. A month later, a cough again was noted and a diagnosis of recurrent fistula was made by barium swallow. At this time she underwent a right thoractomy with resection of the esophageal diverticulum and primary repair of the esophago-bronchial fistula. Her postoperative course was benign. Since then she has done well. She has no difficulty in swallowing and her current weight is 95 pounds.

Comment

The benign type of acquired esophago-respiratory fistula is usually caused by infection or trauma.[2] Rarely, traction diverticulum of the esophagus has been found to be responsible for such a lesion. Although traction diverticula can usually be attributed to preexisting mediastinal infection (e.g., tuberculosis, histoplasmosis) with subsequent contraction of scar tissue, it is not always possible to identify the initial infection.

The patients often complain of a strangulating sensation occuring several seconds after the ingestion of solids or liquids. However, the nature of the symptoms is determined by the site, size,

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Figure. Esophagogram showing a mid-esophageal diverticulum communicating to the right bronchial tree.

and underlying cause of the fistula. Chronic cough, recurrent pneumonia and weight loss are common occurrances. Rarely, a patient may present with hemoptysis and hematemesis.

The diagnosis of this disease is based upon history, physical examination, radiographic studies, and endoscopic examinations. Early diagnosis is important if severe pulmonary complications are to be avoided. Wychulis et al reported various bronchopulmonary complications in about 66% their patients. They recommended bronchographic studies for all patients to outline diseased pulmonary tissue which must be resected at operation.

A wide variety of surgical methods[3,5] and techniques have been utilized in the past for the treatment of this disease. Spontaneous closure of the fistula has been noted only in rare cases. Food and saliva tend to keep the fistula open; however, intermittent closure, as in this case, may occur with nonoperative treatment. The proper therapy for such a fistula is operative; i.e., division of the fistula tract and repair. In addition, proper antibiotic therapy should also be instituted. The operative approach has provided gratifying results as reported by Coleman[4] et al, and others.

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caris lumbricoides (roundworm). The a h
mintic action is probably due to the ru
muscular blocking property of the drug.

Antiminth is partially absorbed after a o
dose. Plasma levels of unchanged dru c
low. Peak levels (0.05-0.13 μg/ml) are re h
in 1-3 hours. Quantities greater than 5% o
administered drug are excreted in fec s
the unchanged form, whereas only 7% c le
of the dose is found in urine as the unch g
form of the drug and its metabolites.

Indications. For the treatment of asc a
(roundworm infection) and enterobiasis p
worm infection).

Warnings. *Usage in Pregnancy:* Reprod t
studies have been performed in anima a
there was no evidence of propensity for a
to the fetus. The relevance to the human s
known.

There is no experience in pregnant w m
who have received this drug.

The drug has not been extensively s d
in children under two years; therefore, t
treatment of children under the age t
years, the relative benefit/risk should b c
sidered.

Precautions: Minor transient elevati s
SGOT have occurred in a small percent e
patients. Therefore, this drug should b s
with caution in patients with preexistin
dysfunction.

Adverse Reactions. The most frequen
countered adverse reactions are relatec
gastrointestinal system.

Gastrointestinal and hepatic reactio
orexia, nausea, vomiting, gastralgia, a
nal cramps, diarrhea and tenesmus, tr
elevation of SGOT.

CNS reactions: headache, dizziness, c
ness, and insomnia. Skin reactions: ras

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dose 1 gram. This corresponds to a sin
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of body weight. (One teaspoonful=5 m

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is not necessary prior to, during, or aft
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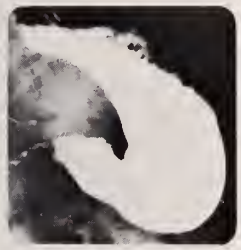

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> Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS. In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with: autonomic neuropathy; hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations; mydriasis, cycloplegia; increased ocular tension; loss of taste, headache, nervousness; drowsiness; weakness; dizziness, insomnia; nausea; vomiting; impotence; suppression of lactation, constipation, bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION. Dosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg. capsule and syrup. *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water.) Bentyl 20 mg : *Adults* 1 tablet three or four times daily Bentyl Injection: *Adults* 2 ml (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine* (bethanecol chloride USP) should be used
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MATERNAL MORTALITY

From the Files of the KMA Maternal Mortality Study Committee

—Edited by John W. Greene, Jr., M.D.

9-75. The patient was a 25-year-old, married, white, primigravida. The patient was a brittle juvenile diabetic from eight years of age, requiring 30 units NPH insulin daily. At the 35th week of gestation, 1+ albuminuria and trace edema were found. Her BP was labile, reaching 200/140. Diuretics were apparently ordered. She was clinically felt to have polyhydramnios and was intended to be delivered by Cesarean section.

On the evening of August 13, the patient developed postprandial nausea and was seen at a hospital. Blood sugar was reported as between 300 and 400 mg%; no urinary acetone. She was hospitalized and treated with small doses of insulin. Later that evening she had a seizure. The diagnosis of toxemia was made. Approximately four hours after admission to the hospital on August 14, the patient was delivered by Cesarean section of a stillborn female infant, which was not weighed.

The following morning she had four more seizures and showed signs of a consumptive coagulopathy with a "low" platelet count of less than 20,000. Oliguria and hematuria were present. At noon on the 14th, the patient was given heparin.

During the first 24 hours the patient was noted to have a "high" blood pressure. She received multiple medications including Keflex, Gentamycin, Aqueous Penicillin, SoluMedrol (1,000 mgm), platelets (5 units), Luminal, Magnesium Sulfate, Demerol and Serpasil. At the 24-hour point the patient was comatose and LP was performed. Protein was 300 mg percent and appeared xanthochromic. She had a BUN of 50, creatinine of 2.7, potassium was 7.2 meq/L. Dilantin and Apresoline were begun.

On August 15, hemetemesis developed. Hematocrit was in the low 20's and seizures continued. The patient received Lasix. On the 16th the seizures continued; a BUN was 116.

On the 17th (fourth postpartum day) the patient developed anasarca, respiratory alkalosis, and gastrointestinal hemorrhage. On the 18th the patient was apparently responding neurologically. On the 19th the patient received a peritoneal dialysis (40 exchanges). She was also transfused with albumin and intense diuretic therapy was employed. Clinical features were persisting gastrointestinal bleed, pulmonary edema and a severe hypoglycemic episode with a blood sugar of 18. Renal function had been deteriorating with a BUN of 40 and a creatinine of 6.1. Respiratory alkalosis persisted, secondary to hyperventilation.

The patient was transferred on the 21st of August (8th postpartum day) to a 298-bed hospital. Soon after admission, the patient developed hypotension and passed melanotic stools.

Physical evaluation at time of transfer was BP 90/70, unresponsive but sedated individual. Central venous pressure line was placed in the subclavian vein (3-6 cm H_2O). HEENT: fundus revealed hemorrhage in the right eye with bilateral retinal edema. SKIN: good color and quality. LUNGS: adequate bilateral ventilation. ABDOMEN: status post-cesearean section, bowel sounds were present. EXTREMITIES: 1+ edema good peripheral pulses, no petechiae or icterus.

Upon transfer the patient's heparin was discontinued and reversed with Protamine (25 mg). She was transfused with blood and treated for a probable state of sepsis. Neurological consultation was obtained. She deteriorated both in renal and neurologic status. She became oliguric, comatose and unresponsive. On the second hospital day she developed ventricular fibrillation and cardiac arrest. Initial resuscitation was successful. Two hours later she developed recurrent ventricular fibrillation which could not be reversed.

An autopsy was obtained. The final diagnosis:

1. Focal fibrin thrombi in cerebral vessels with focal infarction
2. Extensive bronchopneumonia
3. Lower nephron nephrosis
4. Chronic pylenephritis
5. Inflammatory changes in the liver, probably due to sepsis
6. Diabetes
7. Status post C-Section
8. Bleeding diathesis-clinical
9. Depressed platelets-clinical
10. Massive edema
11. Bilateral hydrothorax
12. Abdominal ascites 4-5,000 cc's of clear amber fluid

Comment from pathologist—"It would appear this patient died from a combination of factors rather than a single entity. Probably the most important feature was the diabetes and the subsequent episode of coma with the cerebral damages. Superimposed upon this was very extensive bronchopneumonia anasarca, lower nephron nephrosis, adult hyaline membrane disease and focal infarcts in the brain."

Comment

The Committee on Maternal Mortality classified this as a direct obstetric death with preventable factors. Much has been written concerning the pregnancy complicated by diabetes mellitus. Recent textbooks deal with the proper way to handle this complication, emphasizing maternal control and assessing the fetus so that the time of the delivery can be properly carried out. This is an important aspect both from the maternal and fetal aspects of the disease. The Committee felt that a preventable factor in this case was the fact that pregnancy should have been terminated much earlier when evidence of edema hypertension and albuminuria presented. This is one of the standard indications for termination of the diabetic pregnancy, whether or not fetal maturity has been attained. Another aspect of the management of the diabetic pregnancy is the strict control of blood sugars which have been terms of issue both for maternal and the fetal outcome. This patient was definitely not controlled as to her blood sugars when values of three to 400 miligrams percent were obtained. A classic paper on the treatment of diabetes and pregnancy is that by Karlson and Kjellmer. This paper should be thoroughly studied by all those who care for the pregnancy complicated by diabetes mellitus.

Reference

Karlson and Kjellmer: The outcome of diabetic pregnancies in relation to the mother's blood sugar level. *Am J Obstet Gynecol* 112:213, 1972.

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Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu g/ml$.
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CME

Provided by the Kentucky OB-GYN Society at the request of the KMA Continuing Medical Education Committee

Laparoscopic Sterilization With The Band

Editor's Note: The CME Committee is revitalizing the CME section of The Journal with periodic reports from specialty societies about new and innovative concepts being used within the specialties. The articles also will include the clinical application recommended with described procedures. CME articles will be informative, yet short and concise.

IN the past ten years laparoscopic tubal sterilization has become a widespread and popular surgical procedure. Most of these have been done with electrocautery, and rare, but disastrous, thermal complications have led to the development of mechanical methods of tubal occlusion: hemoclips, spring loaded Hulka clip and Silastic bands.

The Silastic bands were developed independently by Yoon[3] at Johns Hopkins Hospital and Lay[1] at the University of South Florida. The band has an external diameter of 2-3 mm, an internal diameter of 1-2 mm when unstretched, and an internal diameter of 6 mm when stretched, depending upon the manufacturer. They are inert and apparently cause little, if any, tissue reaction.

Laparoscopy is carried out in the usual fashion with the patient in the lithotomy position with catheterization of the bladder and application of an instrument for uterine manipulation, insufflation of 1-2 liters of carbon dioxide through a Virres needle followed by insertion of the operating laparoscope. Either a double or single puncture technique is used. After the pelvis has been inspected, the fimbriated end of each tube is identified. The applicator is then used to grasp just the tube, about 3 cm from the cornu. The tube is then carefully drawn up into the applicator and the band is applied. Both sides are inspected following application of the bands to be sure that the loop of tube appears avascular. Trocars are removed and the skin incisions are closed.

This may be done on an outpatient or inpatient basis. Few patients will have pain not controlled by a single injection of 50 mg of Demerol and/or oral narcotics. The patients may be up and about in two to six hours and return to their usual occupation in two to five days.

Complications are rare and most are related to trying to bring an edematous or infected tube or one bound down by adhesions into the applicator. Under these circumstances it is easy to transect the tube or tear the mesosalpinx. Most of the time this can be handled by application of bands to each end of the tube or by electrocautery.

Rings may be misapplied to the infundibulopelvic ligament, the round ligament, or the broad ligament. Some physicians advocate D & C prior to application of the band, and it is best to do the sterilization just after the menstrual period since it would be possible to trap a fertilized egg in the distal portion of the tube with an ectopic pregnancy possible.

The largest series[2] reported so far of 902 patients, with 3,839 woman months following sterilization, shows only one pregnancy as a result of method failure. The use of the ring is simple, easy to teach, and avoids the complications of electrocautery.

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3. Yoon IB, Wheeles CR Jr: A preliminary report on a new laparoscopic sterilization approach: The silicone rubber band approach. *Amer J Obstet Gynec* 120:132, 1977.

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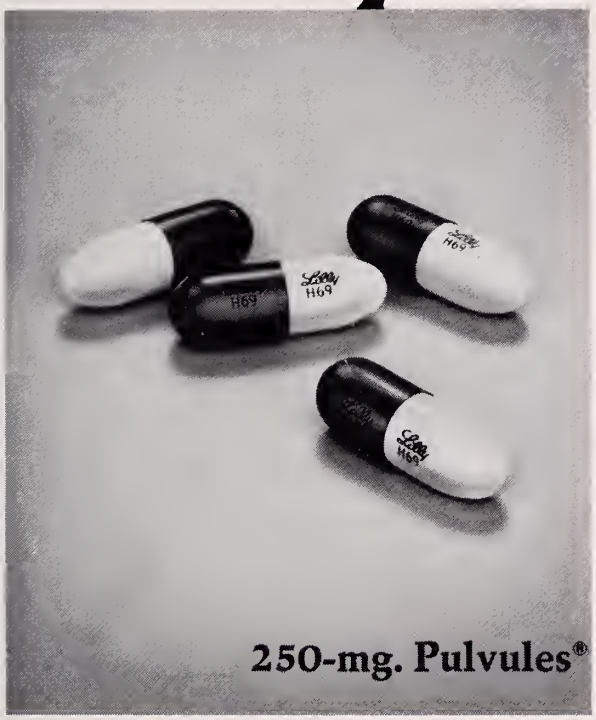

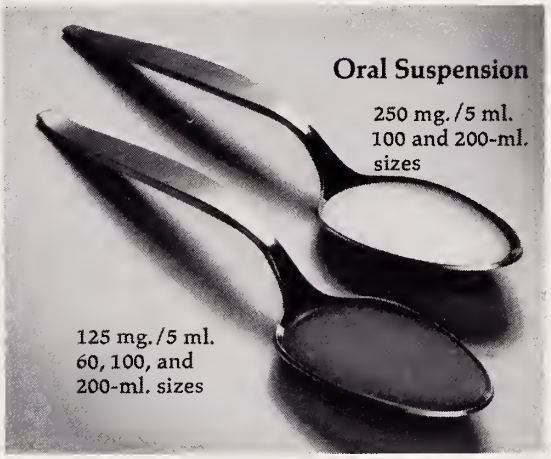

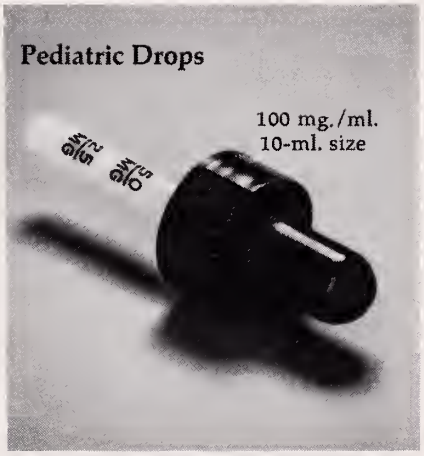

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Case histories on file at Squibb Institute for Medical Research

See next page for brief summary

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CONTRAINDICATION: Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
PRECAUTIONS:
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continue the product and institute appropriate therapy. In presence of an infection, institute use of a suitable antibacterial or antifungal agent. If a favorable response does not occur promptly, discontinue the corticosteroid until the infection has been adequately controlled. If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants. These preparations are not for ophthalmic use.
Usage in Pregnancy—Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not been absolutely established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticos roids—in some cases at rather low dosage levels. Therefore, dru of this class should not be used extensively on pregnant patien in large amounts, or for prolonged periods of time.
Occlusive Dressing Technique—The use of occlus dressing increases the percutaneous absorption of corti steroids. For patients with extensive lesions it may preferable to use a sequential approach, occluding portion of the body at a time. Keep the patient un close observation if treated with the occlusive te nique over large areas and over a considera period of time. Occasionally, a patient who been on prolonged therapy, especially occ sive therapy, may develop symptom steroid withdrawal when the medicatio stopped. Thermal homeostasis may impaired if large areas of body are covered. Disc tinue use of the occ sive dressin elevation of body te perat occu

Occasionally, a patient may develop a sensitivity reac to a particular occlusive dressing material or adhe and a substitute material may be necessary. If infec develops, discontinue the use of the occlusive dr ing and institute appropriate antimicrobial therapy.
ADVERSE REACTIONS: The following local adv reactions have been reported with topical corticoster especially under occlusive dressings: burning sensati itching, irritation, dryness, folliculitis, hypertrichosis, a form eruptions, perioral dermatitis, allergic contact dermat hypopigmentation, maceration of the skin, secondary infect skin atrophy, striae, and miliaria.
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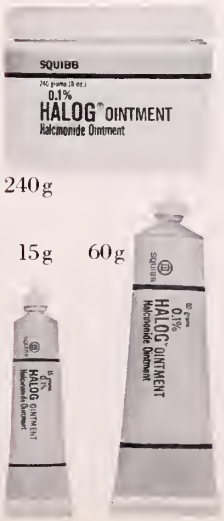

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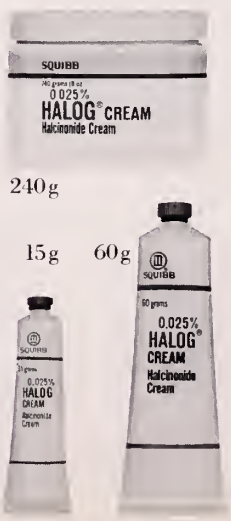

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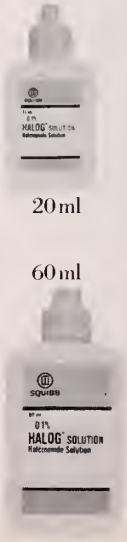

EDITORIAL

Ramapithecus is dead. . . . . .

The few remaining clues of his existence are fragmentary and tell us little about this first erect primate who was our forebearer. Those factors responsible for his demise are unknown but from this primitive homonid several species evolved — all extinct except *homo sapiens*. Climatic changes were the predominant influence on his origin and responsible for his emergence. As certainly as the tropical rain forests of Africa gave way to open woodlands and savannahs, present day changes in our social climate will inevitably result in an evolution in the delivery of health care. Major change throughout the millenia of history and prehistory has invariably produced casualties, and it is difficult to predict how the quality of medicine in the United States as well as its practitioners and patients will survive the upheaval.

When physicians band together as a social animal, their pool of knowledge increases as it does with other higher primates. There is, however, a second major benefit of concerted action among members of a primate group. It is apparent that as the number of baboons or gibbons in a troop increases, so does their chance of survival. This is a basic influence on relations between individuals of a species. Although man is the most flexible and intelligent of all primates, joint defense against predation is more common to the chimpanzee than to the physician.

The future of medicine is inexorably moving towards national health insurance and the majority of physicians are on record in favor of a system of care which will promote the well being of their patients. National health insurance is being championed by a few elected avatars who have assimilated a plan for health insurance from the debris of health care delivery systems less effective and often more expensive than our own. Certain individuals consistently quote data out of context, develop plans compounding the failures of earlier plans, and formulate unsound propositions as a matter of political expediency. We must face these threats in a participative rather than reactive posture.

After national health insurance, the same economic realities including inflation, advancing technology, cost of labor, i.e., the same factors which influence the cost of health care presently, will inevitably stress any poorly conceived system beyond its ability to sustain such forces. Cost containment and arbitrary rationing of care must then be the result.

In an effort to prevent this crisis we must analyze the evolution and results of national health programs in other nations just as systematically as Diane Gifford has studied the fate of animal skeletons on Africa's plains. Her interesting work has demonstrated that carnivores are the principle reason that complete hominid skeletons are never found. Even after the corpse is stripped, hyenas and jackals return to gnaw at the cartilage and disperse the bones. If our present system of health care dies and is replaced by an unworkable substitute incapable of meeting the people's needs, political scavengers will place the responsibility for failure on health care providers and then proceed to further dismember the remains of the system which once was.

Our individual responsibility to our patients, profession, our future and ourselves is clear. The time is past when we can abjure support for our regional and national societies whether it is the American Medical Association, our specialty society or an allied health organization.

"Above all else we . . . [physicians] are social animals; emotionally we need to be part of a group and intellectually we are equipped to understand, and to manipulate interaction with other people, whether parochially as in personal relations or politically."

Failure to perceive the consequences of a changing social climate and neglect of basic social responsibilities by individual members of the medical profession will hasten the day when *Quality in Medicine* will join the fragile *Australopithecus* . . . as a fossil.

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4. Thickening or lump in breast or elsewhere.
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6. Obvious change in wart or mole.
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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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8-3983 (Y572A)

ASSOCIATIONAL NEWS

RILEY LASSITER TO HEAD KENTUCKY MEDICAL INSURANCE COMPANY (KMIC)

The Kentucky Medical Insurance Company (KMIC) Board of Directors is pleased to announce the appointment of Mr. Riley Lassiter as its first chief executive officer. Mr. Lassiter is well-known in the industry and to Kentucky physicians. For the past 19 years, he has been Kentucky's representative for the Medical Protective Company, which currently writes the majority of physicians' professional liability insurance policies in Kentucky. Mr. Lassiter brings many qualities of leadership to the Kentucky Medical Insurance Company (KMIC). "His strong background in sales and claims processing will be invaluable to him in his capacity as the KMIC Executive Vice President," stated Ballard W. Cassady, M.D., Pikeville, Chairman of the KMIC Board of Directors.

Riley Lassiter

The Kentucky Medical Insurance Company was formed this year by the KMA Board of Trustees at the direction of the 1977 House of Delegates.

Mr. Lassiter was born in Muhlenberg County and spent most of his early years in Calloway County until his family moved to Louisville in 1943, where he has resided ever since. He is 47 years old and married to the former Patricia Ann Shaw of Louisville. They have two children, Michael, 26, and David, 21.

A graduate of Fern Creek High School, Mr. Lassiter received his B.S. and Masters degree from Murray State College. Prior to joining the Medical Protective Company as the state representative of Kentucky in 1959, he had taught school and was Assistant Coach at Eastern High School in Louisville.

Doctor Cassady noted that most Kentucky physicians already know Mr. Lassiter as "he has gained our respect during the past nineteen years while serving the Medical Protective Company. We know he brings to the Kentucky Medical Insurance Company a wealth of experience and expertise that will be extremely beneficial to us in the years ahead."

Mr. Lassiter is expected to assume his new duties in late September or early October.

Digest of Proceedings Board of Trustees August 9-10, 1978

A major purpose of the August Board meeting is to review the committee reports prior to their submission to the House of Delegates and to record the actions of the Board on each report for consideration by members of the House. Committee Chairmen and Trustees assigned to study the reports discussed each in detail.

Additional reports were heard by the Board from the President, the Secretary-Treasurer, the Senior Delegate to the AMA, the President of KPRO, and a representative of the Board of Medical Licensure.

A lengthy discussion was held following multiple presentations on the pros and cons of Individual Practice Associations. It was taken by consent that no action was indicated at the present time from KMA concerning involvement in a statewide Individual Practice Association.

There was also a lengthy report presented by legal counsel on the numerous legal matters now affecting medicine generally, and KMA specifically, to include a number of lawsuits in which KMA has voluntarily or involuntarily participated.

Nominees were finalized for presentation to the Governor for appointment to the Comprehensive Health Planning Council; a request to form the Big Sandy Multi-County Medical Society was approved; and numerous comments were made concerning the successful election of Hoyt D. Gardner, M.D. as President-Elect of the American Medical Association.

Another major agenda item was a complete update on progress that has been made with the Kentucky Medical Insurance Company which came into existence on July 31, 1978. Recognizing a need by the Company for financial assistance until it has become capitalized and is generating its own income, the Board of Trustees authorized up to $100,000 to be used as loans to the Insurance Company on an as-needed basis in its formative stages.

Commissioner for Health Services, Mr. Robert Slaton, was present to discuss a number of Department for

Human Resources health matters to include Radiology Regulations, Regional Boards of Health, and other matters of current interest. A lengthy question and answer session was afforded to the Board members.

A full report was given on the forthcoming KMA Annual Meeting to be held in Lexington, and the Board approved Resolutions for presentation to the House of Delegates on subjects of the Legal Trust Fund, Voluntary Effort, and reduced dues for first-year members. After receiving some separate committee reports and selecting a Judicial Council nominee for presentation to the House of Delegates, the Chairman announced that the remaining meetings of the Board of Trustees for this Associational year would be held on September 24 and 27 during the Convention.

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

SEPTEMBER

4 Labor Day—Office Closed
7 Executive Committee, Louisville Board of Medical Licensure, Louisville Committee on Utilization Review, Louisville
12 *Journal* Editors, Louisville
13 McDowell House Board of Managers, Danville
14 Board of Medical Licensure, Louisville
25-28 KMA Annual Meeting, Lexington

OCTOBER

4-6 Officers-Staff Conference, Louisville

IN MEMORIAM

William S. Snyder, Jr., M.D.

Frankfort
1902-1978

William S. Snyder, Jr., M.D., died on August 20, 1978 in Lexington, Kentucky. Doctor Snyder was a surgeon in the fields of ophthalmology and otolaryngology, and had been chief resident of otolaryngology at University Hospital at Western Reserve University, Cleveland. He was past president of the Franklin County Medical Society and the Louisville Eye, Ear, Nose and Throat Society. He also was a life fellow of the American Academy of Ophthalmology and Otolaryngology.

Did you know . . .

John A. D. Cooper, M.D., President of the Association of American Medical Colleges (AAMC), and Hoyt D. Gardner, M.D., President-Elect of the American Medical Association (AMA), participated in the dedication September 19 of a wall mosaic at the University of Louisville School of Medicine Tower at the Health Sciences Center. The mosaic, portraying the late Abraham Flexner, a Louisville native credited with revolutionizing American medical education, was created by Louisville surgeon, Harold F. Berg, M.D.

"Pace Your Energy" is the theme for Kentucky's Third Annual "Energy Awareness Week," to be proclaimed November 12-18, by Governor Julian M. Carroll. Stressing that energy conservation is everybody's business, the Kentucky Department of Energy will direct a week-long, statewide campaign of press announcements, conservation literature hand-outs, poster displays, and energy exhibits and seminars. On November 14, U. S. Senator Wendell H. Ford will be the keynote speaker at the Governor's Energy Awareness Conference, to be held at the Executive Inn West, Louisville.

Members in the news

NEW MEMBERS

CALLOWAY
Richard Crouch, M.D., Murray

CAMPBELL-KENTON
Peter D. Goodwin, M.D., Cincinnati, O.
Ralph F. Huller, Jr., M.D., Erlanger
Thomas M. Mayer, M.D., Ft. Thomas

CHRISTIAN
Duncan R. Campbell, M.D., Hopkinsville

CUMBERLAND
Samuel L. Rice, M.D., Burkesville

MASON
Byran Prater, M.D., Maysville

MUHLENBERG
William R. McGhee, M.D., Greenville

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Brent Brandon, M.D., Pikeville

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Physician Advisors Needed

Kentucky Peer Review Organization

A limited number of Physician Advisor positions will be available for peer review activities in non-delegated Kentucky hospitals. Compensation is $44.00 per hour (plus travel expenses where appropriate). Physician Advisors must have active staff privileges in at least one acute care hospital in Kentucky; however, a Physician Advisor will not be assigned to a hospital where he/she has active staff privileges. One Physician Advisor may serve several hospitals if desired.

Interested physicians should contact:

Morvin A. Bowers, Jr., M.D., Director of Physician Advisor Operations, Kentucky Peer Review Organization, 4010 DuPont Circle/Suite 480, Louisville KY 40207—502/896-2111

All inquiries will be held confidential. Potential Physician Advisors will be contacted depending on geographical need, with preference given to physicians who make the earliest inquiries.

Assistant Professor Critical Care

Approved residency in Surgery and/or Anesthesiology with special training at the PG level in Intensive Care Medicine. Should have experience as instructor in Critical Care Medicine. Modern 10-bed I.C. Unit. $28,000 salary. Write or call Dr. Ballard D. Wright, University of Kentucky Medical Center, Department of Anesthesiology, Room N-260, 800 Rose Street, Lexington, Kentucky 40506, (606) 233-5536.

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Tenuate® ®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Whether overweight is a complicating factor... or just uncomplicated overweight.

Tenuate® Dospan® ©IV
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introitus colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

November 1978
Volume 76
Number 11

Scientific Section 541-554
Influenza Vaccine Recommendations . 564
Annual Meeting News 571

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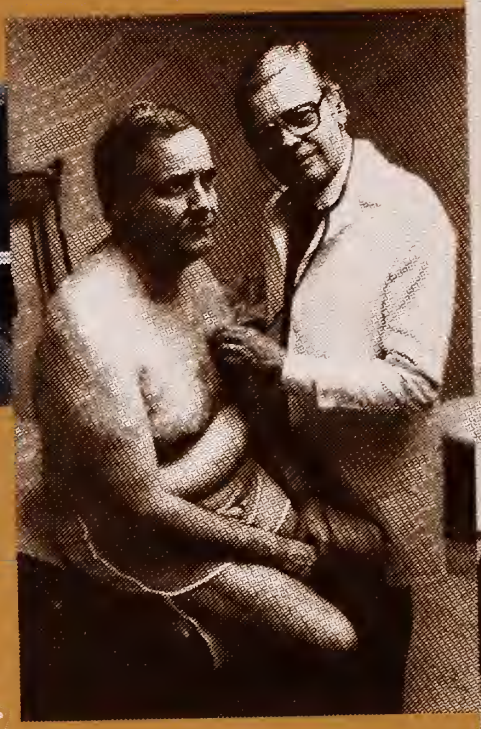

More than two decades of research—including hundreds of animal studies and hundreds of clinical trials—stand behind the proven antianxiety performance of Librium.

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safety record

What excited clinical researchers about Librium was its promise of effective antianxiety action within an unprecedented margin of safety. This promise continues to be fulfilled in millions of patients today— most likely including many of your own.

The highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record. Clinical experience with millions of patients indicates that the most common side effects are dose-related and thus largely avoidable. Tolerance rarely develops at recommended doses. Few cases of known toxicity have been reported. In proper dosage, Librium rarely interferes with mental acuity or produces adverse effects on the cardiovascular or respiratory system. Patients should, however, be cautioned about performing tasks requiring mental alertness, such as driving, and possible combined effects with alcohol.

- ☐ Proven antianxiety performance
- ☐ Minimal effect on mental acuity
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Librium® IV

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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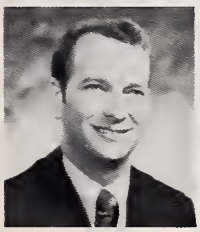
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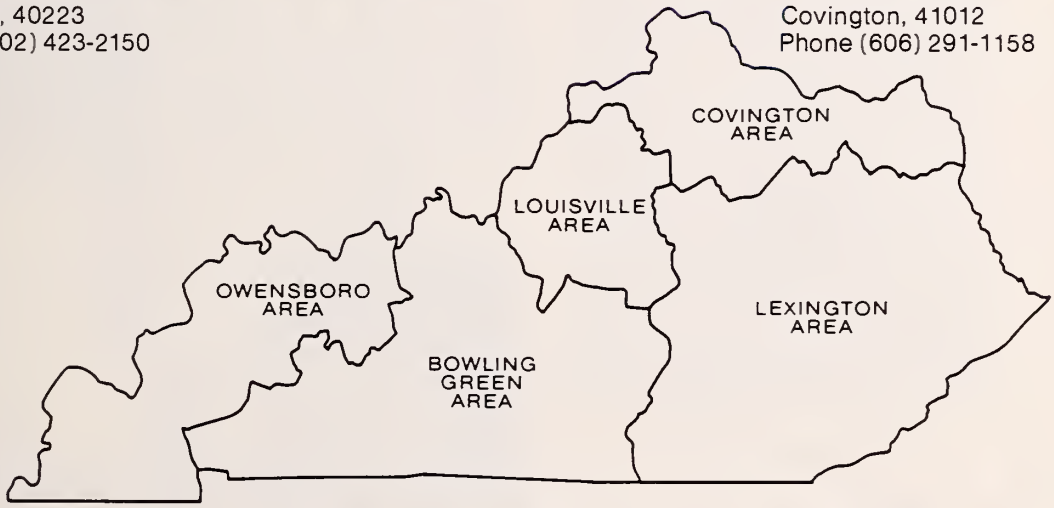

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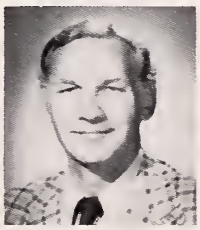
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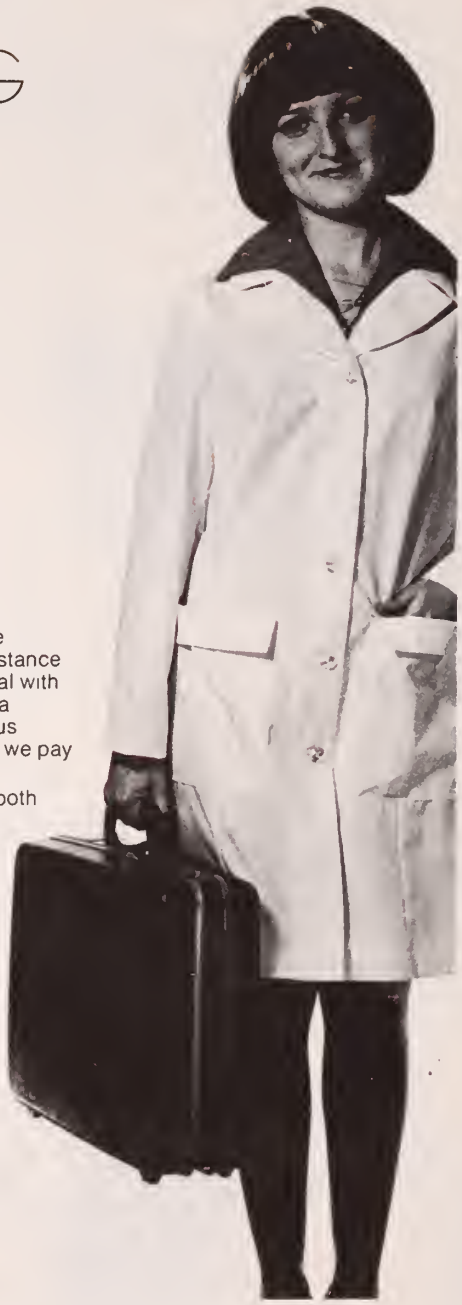

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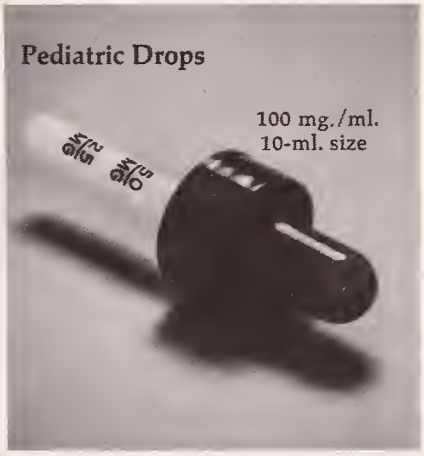

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15-16 "Allergy and Immunology Symposium"**, University of Louisville School of Medicine

3-4 Fiberoptic Bronchoscopy: A Workshop*, University of Kentucky Medical Center, Lexington

16-18 Cancer And Medicine* 1978, Hyatt Regency Hotel, Lexington

28 "Treatment of Sexual Dysfunction," and "Recent Developments in Obstetrics," Kentucky OB-Gyn Society and Kentucky Section of the American College of Obstetricians and Gynecologists. Contact Glenn I. Moore, M.D., 1800 S. Limestone, Lexington, Ky. 40503.

DECEMBER

1-2 Fiberoptic Bronchoscopy: A Workshop*, University of Kentucky Medical Center, Lexington

7 Renal Failure—Pathophysiology and Management.** Hyatt Regency, Louisville

JANUARY, 1979

11 Lecture on Bone Radiology by Freida Feldman, M.D., Guest Lecturer for Bluegrass Radiological Society, Albert B. Chandler Medical Center, Lexington. Contact James G. Lorman, M.D., Dept. of Diagnostic Radiology, U of Ky., Lexington, Ky. 40506

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MESSAGE FROM THE PRESIDENT

NOW that we have concluded the 128th annual KMA Meeting, I would like to reflect upon some of the accomplishments and express a few thought and aspirations for the coming year.

I feel sure that everyone enjoyed the hospitality of the Fayette County Medical Society, the excellence of the scientific program arranged by Doctor Richard Hench and his committee, and the very excellent accommodations of the Hyatt Regency. We thank you all.

During the meeting, and especially during the Reference Committees and the House of Delegates, I felt that some members questioned the intent and integrity of the KMA or possibly of the leadership. I believe this to be due to a lack of communication and we should be able to overcome this problem now and in the future.

As your President, and I thank you for the honor, I would like for any members of the Association who feels that he or she is not being heard by their local, county, or state level to please call me personally at my home or office at any time and I will do my utmost to see that your questions or problems receive attention.

The KMA is your Association and your problems are ours. We will work with you and for you, realizing that the final decision or action resides with the House of Delegates.

Having been long involved with KMA, I know that some of you feel that you cannot work through KMA and must go outside to accomplish your goals. Please let me remind you that the motto of Kentucky, which states "united we stand and divided we fall," is still valid and applies to medicine today on all levels.

With attacks on the freedom of practice of medicine coming from the federal government through many programs—and with our "good friends," Mr. Califano and Senator Kennedy, wanting to practice medicine or dictate how it should be practiced—we must stand united.

I am optimistic for medicine in Kentucky during the coming years, but not without the full support of all physicians and with each of us being willing to carry our share of responsibility.

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CARL COOPER JR., M.D.
KMA President

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There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

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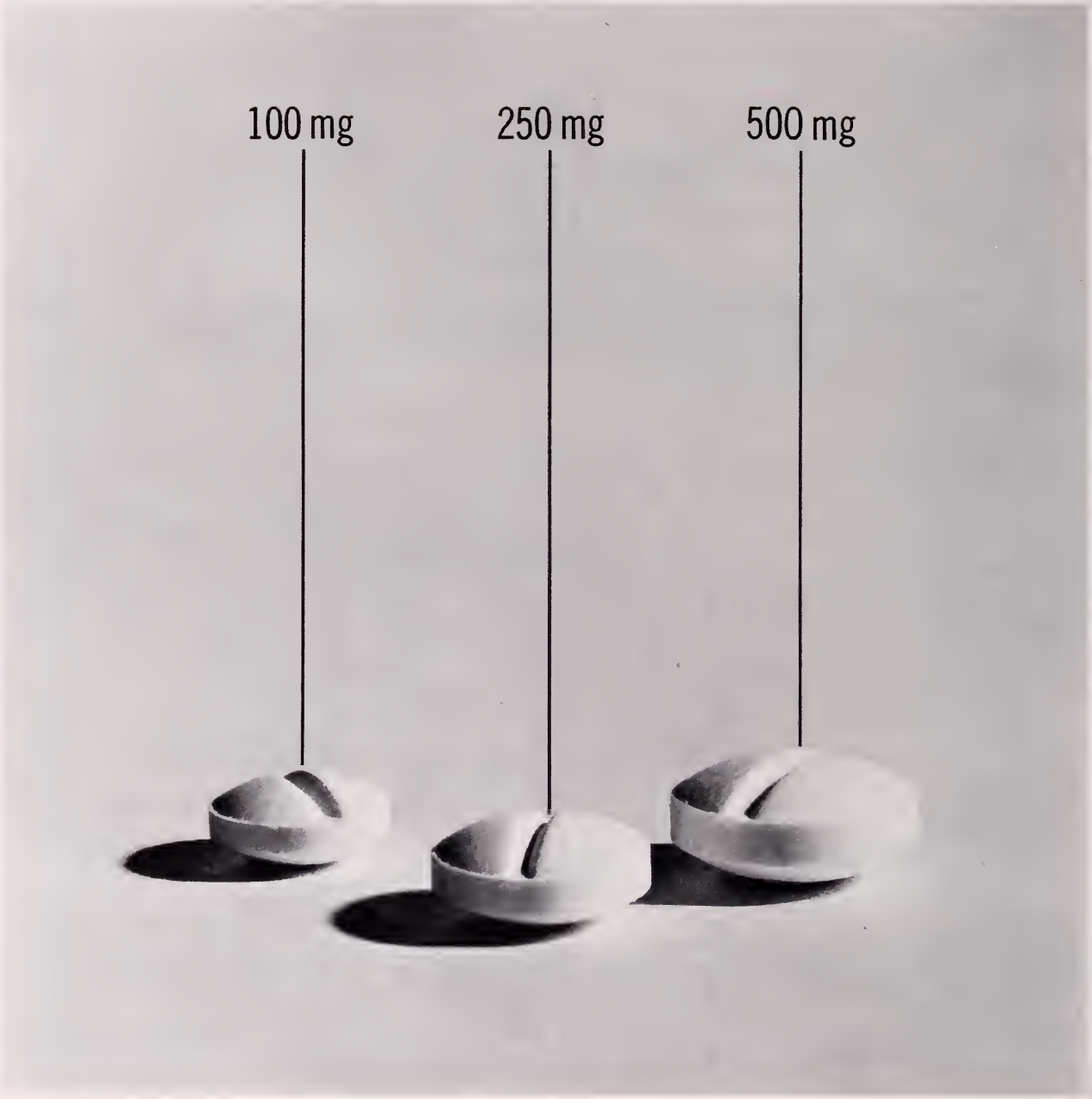

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VOLUME 76 NOVEMBER 1978 NUMBER 11

Why Another Ulcer Operation?

Sally Sherard Mattingly, M.D.

Lexington, Kentucky

To date, truncal vagotomy and antrectomy has been thought to be the best duodenal ulcer operation. It gives the lowest ulcer recurrence rate, but the patients have significant problems with dumping and diarrhea. Selective gastric vagotomy in association with antrectomy or pyloroplasty does decrease the diarrhea. Dumping remains a problem because a drainage procedure is necessary. Proximal gastric vagotomy provides a method for decreasing acid production sufficiently to prevent large numbers of recurrent ulcers yet maintains the normal gastric emptying.

HISTORICALLY there have been many operations devised for duodenal ulcer disease —each with the eponym of its originator. There were gastrojejunostomies, pyloroplasties, various extents of gastric resection, some with gastroduodenal reconstruction and others with gastrojejunal anastomoses, antral exclusion procedures, segmental resections, and lastly, but most importantly, the vagotomies.

It is probably impossible to completely define what the ideal gastric operation should be, but factors such as operative mortality and morbidity, ulcer recurrence rate, and the incidence of post-operative symptoms must be considered in the evaluation.

In the past 20 years, various clinical studies have been tried to determine whether there is an advantage of truncal vagotomy plus antrectomy (TV & A) over truncal vagotomy plus pyloroplasty (TV & P). In reviewing several studies, we can see the results as shown in Table 1.[1-5] At first glance it appears that the operative mortality is comparable with either operation. However, if the TV & A patients are further analyzed, the mortality rate increases to at least 3-4% in high risk patients in all series. Therefore, the recommendation for this group of patients is a TV & P. But if we look at the ulcer recurrence rate, it is highest in those patients with TV & P. Both operations leave patients with a propensity for post-vagotomy problems—dumping and diarrhea. The Visick grading of overall results post-operatively shows that the two operations are fairly comparable.

The principal cause of recurrent ulcer in most patients is an incomplete vagotomy, with most of the recurrences occurring within the first two post-operative years. Because of this and the high rate of post-vagotomy problems, other types of vagotomy have been devised. The selective gastric vagotomy, introduced by Jackson and Franksson in 1948, and popularized by Harkins and Griffith[6] in the late 1950's and the 1960's, was designed to denervate the stomach alone. By preserving the hepatic and celiac branches, this operation was expected to reduce the adverse effects of vagotomy on the biliary tract, pancreas and intestine.

From the Department of Surgery, University of Kentucky Medical Center, Lexington.
Received at KMA 7-7-78

Table 1

COMPARISON OF POSTOPERATIVE RESULTS AFTER TRUNCAL VAGOTOMY AND ANTRECTOMY AND AFTER TRUNCAL VAGOTOMY AND PYLOROPLASTY

STUDY	OPERATION	# PTS	OPERATION MORTALITY	RECURRENT ULCER	VISICK GRADING I & II	VISICK GRADING III & IV	DUMPING	DIARRHEA
Goligher-Leeds/York	TV & A*	132	0	1% (6 yrs)	77%	23%	13%	23%
Jordan	TV & A	90	0	1.1% (1-8 yrs)	89%	11%		
Herrington, Sawyers, Scott	TV & A	3584	1.6%	0.6% (1 to 20 yrs)	94%	6%	25%	10%
Bruce	TV & P+		1%	3.1%				30%
Bryant, Griffen	TV & P	112	0	17.9% (1 up to 10 yrs)				
Weinberg	TV & P	1129	0.5%	4.5% (1 > 10 yrs)	92%	8%		

*Truncal vagotomy and antrectomy
+Truncal vagotomy and pyloroplasty
The references for this table are 1-5.

Randomized prospective studies of truncal vagotomy (TV) with drainage, versus selective gastric vagotomy (SGV) with drainage, were done. The results with respect to dumping and diarrhea are shown in Table 2.[6,7] The incidence of diarrhea was reduced with selective vagotomy, but dumping was not. Operative mortality was low and the same in each group. An ulcer recurrence rate of less than 2% with selective vagotomy and pyloroplasty was understandable, in light of the fact that there were fewer positive Hollander tests in patients with this operation. Sawyers and Scott[8] showed that there was statistically no significant difference in the long term results of patients who have had selective vagotomy with either antrectomy or with Finney pyloroplasty. Probably because of the careful dissection involved in selective gastric vagotomy, variations in the number and anatomy of the vagus nerves are better appreciated and thus this operation offered a superior method for achieving completeness of vagotomy.

Because selective gastric vagotomy accomplishes complete and total vagal denervation of the stomach, gastric stasis still occurred. A drainage procedure was necessary, and therefore dumping still occurred. Further experimentation proceeded to devise a better operation.

Proximal gastric vagotomy (PGV)—also known as parietal cell vagotomy, partial gastric vagotomy, highly selective vagotomy, proximal selective vagotomy—may be the answer. In 1957, Griffith and Harkins[9] reported evidence in dogs that with this vagotomy, only the parietal cell mass was denervated and the cephalic phase of gastric secretion was eliminated. Innervation of the antrum, pylorus and duodenum was preserved as well as vagal innervation to all other abdominal viscera. Holle and Hart in 1967 reported the first group of patients who underwent proximal gastric vagotomy with an added drainage procedure. Critics have wondered about preserving the innervation of the antrum if a drainage procedure was to be done.

Amdrup and Jensen[10] and Johnston[11] in 1970 reported their experience using proximal gastric vagotomy alone. Follow-up study was short at that time, but their patients appeared to have normal gastric emptying and no dumping. The technique of operation was critical in order to preserve enough antral innervation to ensure good emptying and not leave proximal fibers that would result in a recurrent ulcer.

Many studies have been performed to determine the effect of PGV on gastric motility and empying in animal models and in patients. There seems to be a quick initial emptying phase, but the bulk of the meal empties essentially as in controls.

Table 2

COMPARISON OF POSTOPERATIVE RESULTS AFTER TRUNCAL VAGOTOMY AND SELECTIVE GASTRIC VAGOTOMY

	DUMPING		DIARRHEA		+ HOLLANDER	
Study	TV*	SGV**	TV	SGV	TV	SGV
Sawyers	21%	34%	21%	12%	19%	2%
Harkins, Griffith	8%	19%	68%	29%		6%

*Truncal vagotomy
**Selective gastric vagotomy
The references for this table are 6 and 7.

Table 3

POSTOPERATIVE RESULTS AFTER PROXIMAL GASTRIC VAGOTOMY FOR DUODENAL ULCER

STUDY	# PTS	MORTALITY	RECURRENCE	GASTRIC ULCER	DUMPING	DIARRHEA	EPIGASTRIC FULLNESS
Grassi	85	0	1% (to 4 yr)	0	0	0	3%
Johnston	271	0	0	2%	5%	4%	
Amdrup	(108)						
Sawyers	174	0	1%	2%	1%	1%	16%

The references for this table are 12-14.

A compilation of early results is shown in Table 3.[12-14] The patients in these series underwent uncomplicated, elective operations; none had acute hemorrhage, acute perforation, or severe gastric outlet obstruction. There was no mortality and the recurrent ulcer rate was low. Dumping and diarrhea were minimal. The epigastric fullness appeared to be a short-term problem with most of the symptoms disappearing within two months. The gastric ulcers were probably due to gastric stasis on the basis of too much denervated antrum. Sawyers and Herrington[14] showed in a prospective, randomized study, that there was a stastistically significant difference in favor of patients who were symptom-free with PGV as opposed to those who underwent TV & A. They also randomized PGV versus SGV & P and did not find a statistical difference, but had evidence that there were more satisfied patients in the PGV group.

Wound infections are less common, as should be expected since the lumen of the intestinal tract is not opened. PGV is the most minimal elective surgical procedure for duodenal ulcer, and if it fails, PGV can be followed by any other operation of gastric surgery. Only more follow-up studies will tell, but at present proximal gastric vagotomy appears to be *the* operation for elective duodenal ulcer patients.

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Breast Thermography

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Received at KMA 6-8-78.

In its present state of the art, breast thermography cannot be used as a sensitive screening or prescreening test for the detection of favorable breast cancer. However, continued vigorous efforts to completely exhaust the potential of this safe and acceptable screening technique are justified.

THERMOGRAPHY is a method of detecting and photographically imaging infrared radiation from a body surface. Breast thermography records the infrared emissions from each breast routinely imaged in the anterior posterior (AP) and oblique projections (Figure 1). Temperature elevations are reflected on the breast surface via the superficial veins (Figure 2). The temperature variations produce asymmetrical thermal patterns (Figure 3), resulting from underlying tissue changes.[5,11,12,15,21] The asymmetrical presentation has no specificity and may be a manifestation of a physiologic change in normal breast tissue, may represent benign disease or may be an indication of malignancy.

An understood prerequisite to accurate mammotherm analysis is strict adherence to accepted thermographic techniques. One must be familiar with the variations reflected in the surface veins of the normal female breast as well as the objective criteria for identifying the abnormal thermogram. Many excellent papers have been written on the basics of technique and interpretation and interested readers are referred to these.[7,9,10,11,15] Our experience reemphasizes the importance of proper patient cooling and careful patient positioning. In addition, the interpretative accuracy may be seriously affected by the examination sequence. The thermographic examination should always precede the clinical and mammographic examinations.[2]

In the late 1960's and early 1970's, breast thermography established itself in several centers with varying, yet acceptable, true positive and true negative rates.[1,5,9,11,17,20,21] The most favorable results, however, related to symptomatic patients with more advanced cancers.

The value of thermography in the screening of asymptomatic women for breast cancer was not known, as results in the early individualized screening programs varied widely.[4,6,8,18]

In this climate of hope but confusion, breast thermography was included in the 27 American Cancer Society/National Cancer Institute (ACS/NCI) screening centers established in 1973 and 1974 throughout the country. After five years of investigative effort, the results are disappointing when thermographic interpretation is correlated with occult cancers. At the University of Louisville Breast Cancer Demonstration Project, 129 breast cancers have been confirmed. Forty-nine (37.9%) had thermograms interpreted as positive. Almost this exact percentage of all women coming through the Breast Cancer Demonstration Project have thermograms interpreted as

Figure 1. AP and both oblique projections are routine views for breast thermography. Note abnormal thermal pattern with an increase in heat in the screenee's left breast. (Black is hot.)

Figure 2. Three variations of normal breast thermograms. Vascular pattern left; avascular pattern center; mottled pattern right.

abnormal. Breast size, breast tissue type, tumor location and histologic tumor type seem to have little, if any, relationship to the positive or negative nature of the thermogram. Also, the patient in whom the thermogram has changed from one year to the next, at least to date, does not seem to be at an elevated risk. It does, however, seem true that the patient with the more advanced disease is more likely to have a positive thermogram. An objective evaluation by Moskowitz, et al[16] indicated that in its present state, breast thermography has a limited role as a screening or prescreening modality for early breast cancer.

At the current state of the art, the expectations for breast thermography have not been reached or even approached. Its use as a noninvasive, accurate and inexpensive prescreening test for breast cancer detection has not been established and at the present time further investigation has even been threatened.

The most avid proponents have never suggested that thermography of the breast can diagnose breast cancer. Yet, many hold out hope that the examination will prove to be a significant risk indicator. Isard,[12] Byrne,[3] and Stark[18] in their studies report a rather marked "risk elevation" in those patients with positive thermograms. Our own studies show a four times greater risk in those patients with an abnormal thermal pattern. In addition, Jones, et al[14] suggests a possible value of breast thermography as a prognostic indicator.

The future of breast thermography remains clouded. Technical refinements in instrumentation will undoubtedly improve our accuracy. Computer readouts, already under investigation, will lend objectivity to our interpretations. Stress tests to differentiate benign lesions and normal variations from an underlying malignancy are being developed. Controlled, carefully structured clinical trials are desperately needed. Certainly, continued vigorous efforts to completely exhaust the potential of this safe and acceptable screening technique are justified.

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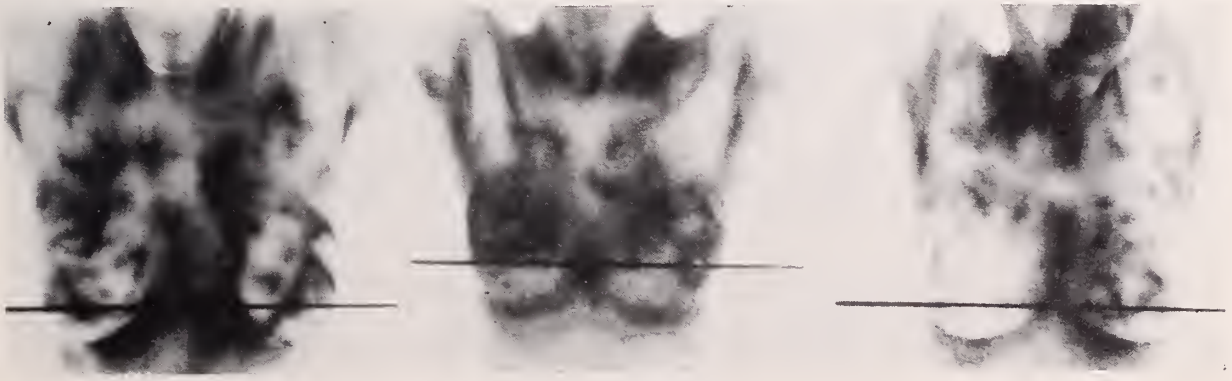

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Brain Stem Electric Testing

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Louisville, Kentucky

BERA is a new, safe, easy electrical test of the cochlea and brain stem. Its specific indications at present seem to be diagnosis of acoustic neuromas and testing of the integrity of the acoustic pathway in infants and uncooperative patients.

ELECTRIC response of the brain to an auditory stimulus could not until recently be evoked in the clinical setting (office). The development of small computers has made it possible to extract these responses from background electrical activity of the brain.

Basis of Electric Response Testing

The rationale of brain stem electric testing is to be able to record the potentials that arise in the cochlea and brain in response to a sound stimulus. An averaging computer has made this possible in a clinical setting (Figure 1).

The sound used is one of a short duration (click or tone burst). This brief sound produces a discharge in the auditory system. The sound can be measured as it travels into the cochlea, eighth nerve, brain stem, midbrain, and cortex. The interpretation of the peak and latency is Brain Stem Evoked Response Audiometry (BERA). The technique and use of the averaging computer obviously cannot be discussed in this short paper.

Definition of Electric Response Audiometry

The three types of testing are: 1) Electrocochleography—This test measures the cochlea and eighth nerve directly and is the most accurate of all the electric response testing, 2) Brain Stem Response Audiometry (BERA)—This is the most widely used and simplest test to perform. No anesthesia is needed and the results are accurate, and 3) Cortical Evoked Response Audiometry—This test is easy to perform but results are not reliable. Sedation and anesthesia affect results.

The testing named electrocochleography will not be explained except to say that it is useful in threshold testing, Meniere's disease, and mapping of the cochlea.

Brain Stem Evoked Response Audiometry or "BERA"

Most of clinical testing is "BERA." It is easy to perform and easy to interpret. It must be said that we are only just beginning to understand the tremendous potential of brain stem testing.

Some indications are: 1) threshold testing of infants, especially high risk infants (premature), 2) testing of very young children and retarded patients, 3) malingerers, 4) diagnosis of acoustic neuromas, and 5) diagnosis of brain stem lesions.

Threshold Testing

BERA is not a hearing test but can accurately determine if the inner ear, eighth nerve, and brain pathway are normal. We should use BERA only if standard audiological testing methods fail. BERA could identify hearing impairment much earlier and can rehabilitate earlier.

Acoustic Neuroma Diagnosis

The latency of Wave V is extremely accurate (97%) in the early diagnosis of acoustic neuromas (Figure 2). How does BERA fit into the

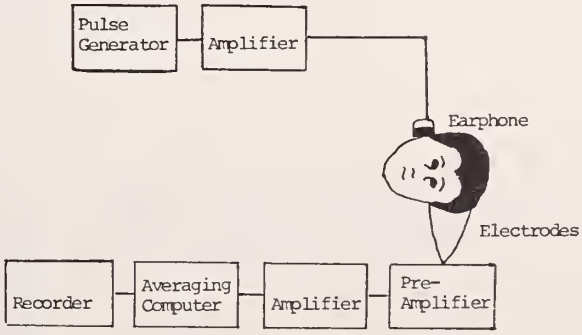

Figure 1. Clinical arrangement of equipment for brain stem testing.

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Received at KMA 8-14-78

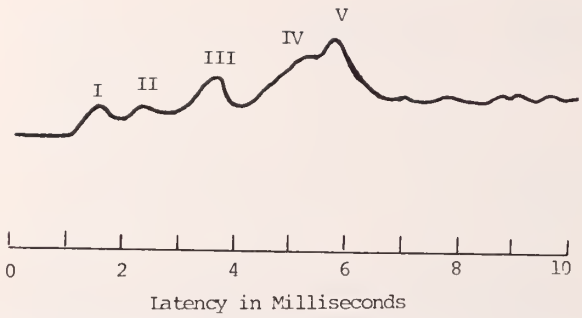

Figure 2. Brain stem electric audiometric responses in an adult patient with normal hearing.

evaluation of a patient with a possible acoustic neuroma? A patient who presents as a possible acoustic neuroma suspect undergoes petrous pyramid X-rays, electronystagmography, and stapedial reflex testing. If all are normal no further tests are done. If the X-rays are definitely abnormal, either CAT scan or contrast dye study is done. If the X-ray is only slightly abnormal and the other testing is normal, or if the X-rays are normal but the other tests still suggest an acoustic neuroma, BERA is done. If BERA is normal then no further testing need be done. The patient should be re-evaluated in six to eight months to eliminate the 2-3% false negative. If BERA is positive, a complete work-up is indicated. The final diagnosis is always done with dye study or a CAT scan.

Brain Stem Lesion Diagnosis

The size of the acoustic neuroma can sometimes be estimated by the presence or absence of Wave I. Often the increased latency of the Wave III to Wave V interval can indicate a brain stem lesion or brain stem shift.

Summary

BERA is new and exciting. We are only beginning to understand the implications of this test, but at present the indications seem to be: 1) threshold testing in infants or uncooperative patients, and 2) high percentage of accuracy in diagnosis of acoustic neuromas.

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GRAND ROUNDS

University of Kentucky College of Medicine

This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

The Zollinger-Ellison Syndrome: Some New Perspectives

A case report of a patient manifesting some of the cardinal features of the Zollinger-Ellison syndrome (ZES) is presented. These features of the Zollinger-Ellison syndrome, including clinical manifestations, diagnostic tests, and treatment modalities are discussed. The clinical spectrum associated with the Zollinger-Ellison syndrome, as well as the number of underlying conditions causing the clinical picture, have greatly increased in number during the last decade. A new therapeutic approach utilizing Cimetidine, an H_2-receptor antagonist is discussed. This drug probably should not be used for primary treatment of patients with Zollinger-Ellison syndrome. However, Cimetidine may be useful to prepare patients with Zollinger-Ellison syndrome for definitive surgical therapy.

Introduction

There are a number of patients who fail to respond to the usual nonoperative therapy prescribed for peptic ulcer disease. Most of these patients will then be treated by a surgical procedure, either for complications of their disease (e.g. hemorrhage, perforation, or obstruction) or for intractability. Occasional patients come to the attention of the physician with unusually severe or persistent disease that, in spite of these measures, requires further evaluation. This might include tests such as barium studies, gastric acid analysis, and radioimmunoassay for serum gastrin. A few of these patients will be found to have the Zollinger-Ellison syndrome.

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In 1955, Zollinger and Ellison[1] discussed the case histories of two patients with relapsing and progressive peptic ulcer disease in spite of aggressive medical and surgical therapy. Both of these patients required total gastrectomy in order to control their disease. The clinical picture presented by these two patients, now called the Zollinger-Ellison syndrome (ZES), consisted of a fulminant peptic ulcer diathesis, gastric hypersecretion, and a non-Beta islet cell tumor of the pancreas. Although cases of intractable peptic ulcer disease in association with a tumor of the pancreatic islets had been reported,[2,3] Zollinger and Ellison were the first to speculate on a cause and effect relationship. They hypothesized in 1955, without any concrete evidence, that the tumor produced an ulcerogenic factor. This factor has since been identified as the hormone, gastrin. It is now well established that the massive gastric hypersecretion of acid is in response to elevated circulating levels of gastrin. These unusually large amounts of gastrin are in turn due to the hypersecretion of a gastrin-producing tumor of the pancreatic islets or duodenal region commonly known as a "gastrinoma."

The study of this syndrome and the identification of a number of allied conditions associated with an elevated level of serum gastrin have contributed greatly to the understanding of gastric physiology and the pathophysiology of peptic ulceration. Also of importance is the contribution that has been made to the understanding of the neuro-endocrine system in general.

A recent case from the University of Kentucky Medical Center illustrates many of the clinical and pathologic features of the Zollinger-Ellison syndrome.

Report of a Case

D.J. is a 42-year-old black female admitted to the UKMC in June, 1978. She presented, acutely ill, to the Emergency Room with a one-week history of nausea, vomiting, mild hematemesis, and epigastric pain radiating to the right side. There was no complaint of melena. She had a long history of peptic ulcer and burning epigastric pain relieved by antacids. Two and one-half years earlier she had undergone a vagotomy and pyloroplasty for an obstructing duodenal ulcer at another hospital. An appendectomy had been performed at that time. A recent oral cholecystogram was negative for gallstones. A review of her GI system was otherwise unremarkable. She had a past history of heavy tobacco and ethanol use. Her medications were "antacids," "ulcer pills," and "nerve pills."

On physical examination she was found to be in moderate distress with a BP of 160/104 and P of 92/min. She was afebrile. Her abdomen was flat and soft, but was diffusely tender to deep palpation, especially in the RUQ. There was no rebound or guarding. The bowel sounds were active. No masses were palpable. Pelvic and rectal examinations were normal. The stool was guiac+ + + + for occult blood.

Initial laboratory evaluation was essentially normal. The EKG was within normal limits except for a sinus tachycardia. A chest X-ray showed no active disease. An acute abdominal series showed silver clips marking the previous vagotomy sites. There was no evidence of obstruction or perforation. The colon was impacted with feces. The serum electrolytes were normal except for a HCO_3 of 38 mEq/L. The amylase was 193 dye units (normal up to 200 dye units). Liver function tests were normal. The CBC was 16,000 WBC with 86 SEGS and 5 BANDS and a 46% HCT. The sickle cell prep was negative.

A gastrografin upper GI series was obtained and showed a large ulcer in the region of the duodenal bulb and a possible second gastric ulcer with prominant mucosal folds. Gastric analysis showed a two hour basal acid output (BAO) of 36 mEq H^+/hr and a pentagastrin stimulated maximal acid output (MAO) of 48 mEq H^+/hr. The BAO:MAO ratio was 0.75. The basal gastric secretion was 350 cc/hr. She began to have diarrhea and developed hypokalemia (3.0 mEqK^+/L).

The initial serum gastrin level was 364 pgm/ml. A repeat value was 627 pgm/ml. A secretin infusion test showed an increase in the serum gastrin level from 1362 pgm/ml to 2566 pgm/ml at 45 min. (an approximately 2 fold increase). The normal value of serum gastrin is considered to be 50-150 pgm/ml. These findings were considered diagnostic of the Zollinger-Ellison syndrome. A urinary screen for 5HIAA was negative. Endoscopy demonstrated esophageal erosions, severe gastritis, and deformation of the gastric antrum with an active channel ulcer. She was started on Cimetidine 300 mg I.V. q. six hrs. Visceral arteriography was performed but there was no evidence of a tumor in the upper GI tract, liver or pancreas. Skull films with attention to the sella turcica were normal. The serum Ca^{++} was 5.2 mEq/L.

Table 1

ETIOLOGIES OF THE ZOLLINGER-ELLISON SYNDROME

1. Malignant Gastrinoma
2. Benign Gastrinoma
3. Antral G-Cell Hyperplasia (Gastrinosis)
4. Pancreatic Islet Cell Hyperplasia

On the night before her operation, she developed massive upper GI bleeding. She was resuscitated and taken to the operating room where she underwent oversewing of a bleeding gastric ulcer. Exploration of her abdomen revealed a small nodule on the posterior wall of the duodenal bulb near the site of previous pyloroplasty. A frozen section diagnosis of carcinoid tumor was later revised to islet cell tumor. An enlarged lymph node was submitted which was initially reported as negative for metastatic tumor, but was found to be positive on permanent histologic section. No other masses were found. She then underwent a total gastrectomy with an esophago-jejunostomy and Roux-en-Y jejuno-jejunostomy. She tolerated this procedure well and had an uncomplicated postoperative course.

She continues to do well. On her first clinic visit she complained of symptoms suggestive of postprandial "dumping" that have since resolved. She is now gaining weight. A postoperative serum gastrin level was 79 pgm/ml.

Discussion

The exact incidence of the ZES is unknown. Estimates vary from less than one per 100,000 in the general population[4] to less than 1% of all patients with peptic ulcer disease.[5] These figures would translate into roughly 20-30 patients with ZES in Kentucky at any one time. The national registry of patients with ZES now includes several thousand. There is a slight male preponderance of the disease and all age groups from nine to 90 are represented.

The acid stimulating properties of gastric antral mucosa were discovered over 75 years ago by Edkins.[6] Since that time, the responsible agent, the hormone gastrin has been identified and even synthesized. Gastrin is a polypeptide that belongs to a family of closely related molecules with vastly different molecular weights. Interestingly, all of the known physiologic properties of this family of proteins can be reproduced by the four terminal amino acids in the sequence. Pentagastrin (used in gastric acid stimulation tests) has five amino acids and is the alanine-NH_4 derivative of this active terminal sequence. Analysis of the amino acid sequences of these molecules suggests a close kinship with other known GI hormones that have slightly different functions.

Gastrin is produced throughout the upper GI tract, predominantly in the G-cells of the gastric antrum. These G-cells belong to the neuroendocrine or APUD (*A*mine *P*recursor *U*ptake and *D*ecarboxylation) family of cells that are embryologically derived from the neural crest and form an intermediate class of cells between the nervous and endocrine systems. These cells are capable of producing both polypeptide hormones and neurotransmitters like serotonin. The metabolic breakdown product of serotonin called 5-Hydroxy Indole Acetic Acid (5HIAA) can sometimes be found in the urine of patients with ZES.

There are now four etiologic factors that have been identified with the Zollinger-Ellison syndrome listed in Table 1.[7] Other conditions associated with an elevated serum gastrin are listed in Table 2. The exact cell that gives rise to a gastrinoma is not known with certainty. Most commonly, these tumors are found in the pancreas or behind the second portion of the duodenum. There is a predominance of multiple tumors. There have been reports of gastrinomas located in the parathyroid glands, in the periaortic and prepancreatic lymph nodes, and as metastatic lesions in the liver with no apparent primary source. Greater than 60% of these tumors are malignant. This behavior cannot be predicted histologically, but depends upon the demonstration of invasion or metastasis.

Since the original description, the spectrum of ZES has undergone certain modifications. With the ready availability of radioimmunoassay for serum gastrin level, more patients are being identified with a much milder state of peptic ulcer disease. Recent authors have stated that the original criteria of a virulent peptic ulcer course and the demonstration of a tumor at the time of laparotomy are no longer diagnostic requisites.[8] Today, the diagnosis is made by the demonstration of gastric hypersecretion and elevated levels of serum gastrin or a positive response to provocative tests. The syndrome now includes a small group of patients (less than 10%) without ulceration who instead have diarrhea and steatorrhea. Until recently, ZES was undiagnosed in over 60% of patients at the time of their first ulcer operation.

Table 2

CONDITIONS ASSOCIATED WITH AN ELEVATED SERUM GASTRIN LEVEL OTHER THAN THE ZOLLINGER-ELLISON SYNDROME

1. Duodenal ulcer
2. Gastric ulcer
3. Retained gastric antrum following a Billroth II procedure
4. Gastric atrophy following antrectomy
5. Gastric outlet obstruction
6. Achlorhydria
7. Short bowel syndrome
8. Cimetidine treatment

Most patients with ZES have ulcers in the upper GI tract. These ulcers are single 90% of the time and occur in the duodenum in about 60%. Without the use of serum gastrin levels and provocative tests, these patients would be difficult to distinguish from other patients with peptic ulcer disease. A more suspicious finding is ulceration in the jejunum found in approximately 15%. This finding is considered by some to be pathognomonic of ZES.

A barium study might typically show single or multiple ulcers anywhere in the upper GI tract. Characteristic findings are hypertrophied gastric rugal folds, an edematous small bowel mucosa and dilution of the contrast material by the increased gastric secretion.

Gastric acid analysis is usually performed with the patient not taking antacids or Cimetidine which increases serum gastrin slightly. A BAO of greater than 15 mEq H^+/hr, or concentration (BAC) of greater than 100 mEq H^+/L is suspicious. In ZES, the acid production is already almost maximal and a little additional gastric acid stimulation can be achieved with either pentagastrin or histalog. The BAO:MAO ratio is therefore usually greater than 0.60. Basal gastric secretion exceeding 100 cc/hr is another suspicious finding.

A serum gastrin level greater than 1000 pgm/ml is considered diagnostic of ZES.[9] There are many patients with more equivocal values of serum gastrin falling into the 100-500 pgm/ml range. Patients with duodenal ulcer may have

serum gastrin levels in the 600 pgm/ml range following a meal, but might otherwise be within the normal range. Patients with gastric atrophy or achlorhydria may have serum gastrin levels within the ZES range of up to 1000 pgm/ml.

There are several useful diagnostic tests that can distinguish patients with ZES from other patients with any of the non-ZES causes of an elevated serum gastrin. The calcium infusion test should show a slow rise in the serum gastrin level. This test depends upon the potentiation of gastrin release by Ca^{++}. The secretin infusion test is considered diagnostic if the level of serum gastrin is doubled during sequential determinations. Secretin normally suppresses the release of gastrin by antral G-cells but paradoxically stimulates the release of gastrin by gastrin-producing tumor cells.[10] Measurements of serum gastrin following ingestion of standard meal is also useful in differentating antral G-cell hyperplasia from ZES. In the presence of a gastrinoma there would not be an elevation of the serum gastrin level in response to the meal.

There are no endoscopic findings characteristic of ZES. Endoscopy may be valuable in determining the extent of ulceration.These tumors are less vascular than other polypeptide-producing tumors, such as "insulinomas," and have a much poorer yield of information from visceral arteriography.[11] When arteriograms are positive, the tumor can be identified by the characteristic "tumor blush" seen in the pancreaticoduodenal region.

Approximately 25% of patients with ZES may have an associated endocrinopathy although this pattern also appears to be changing.[8] Most common is hyperparathyroidism which is associated with hypercalcemia. Some authors feel that this might be part of a normal physiologic response to the chronic metabolic alkalosis found in ZES. There is also a familial pattern of ZES that belongs to the multiple endocrinopathy type I (MEA I) or Wermer's syndrome. This syndrome consists of a combination of a pituitary adenoma with a parathyroid adenoma and a gastrinoma. Other endocrine tumors may also be present. The evaluation of a patient with ZES should include screening tests for these problems.

Once the diagnosis of ZES has been made, the treatment of choice is a total gastrectomy and reconstruction procedure that will prevent the complications of bile reflux esophagitis. At the time of operation, a thorough search of the pancreas and duodenal region is made. Any discrete lesions are removed, but because of the high incidence of multicentricity, malignancy, and local spread, attempts to remove all of the tumor have been discouraging.[12]

There are several case reports of the successful removal of solitary lesions in the pancreas or adjacent to the duodenum with resolution of the peptic ulcer disease and satisfactory long-term follow-up.[13] Unfortunately, these cases constitute the exception. If the preoperative evaluation is equivocal and no tumor is found, it is probably reasonable to perform a vagotomy and antrectomy and then follow the patient closely with repeat serum gastrin determinations. In documented cases of ZES, procedures other than a total gastrectomy have generally met with unsatisfactory, or even disastrous, results. The multiple complications associated with recurrence of the peptic ulcer often outweigh even the problems associated with a malignant gastrinoma.

The postoperative care following a total gastrectomy is challenging. There must be special attention given to alimentation and weight loss. These patients require iron, calcium and vitamin supplements and should receive regular injections of vitamin B-12. The return of serum gastrin levels to normal is associated with a more favorable prognosis, however it has been pointed out that the absolute value of the serum gastrin cannot be used to predict malignancy or metastasis or survival.

Recently there have been reports of successfully treating patients having ZES with Cimetidine alone or in combination with anticholinergics and antacids.[14] There are even some surgeons and gastroenterologists who would remove this disease from the surgical sphere of influence altogether.[15,16] This development was discussed at the most recent meeting of the American Surgical Association.[8] It was the concensus that while Cimetidine is useful in preparing the patient with ZES for surgery, this is not the optimal treatment of this disease.

Table 3

PATIENTS REQUIRING FURTHER EVALUATION FOR ZOLLINGER-ELLISON SYNDROME

1. A young person with severe ulcer symptoms
2. A person with initial ulcer symptoms late in life
3. Recurrent ulceration following an adequate surgical procedure
4. Post-operative or post-partum ulceration
5. Ulceration accompanied by persistent diarrhea
6. Ulceration associated with hypercalcemia or any other endocrinopathy
7. Family history of endocrinopathy
8. Multiple ulcers or ulcers in unusual locations

With the increasing popularity of Cimetidine in the treatment of peptic ulcer disease, we raise the question of whether or not the present trend of earlier identification of patients with ZES will be reversed, the present report being a case in point. This obviously depends upon the awareness of physicians of the Zollinger-Ellison syndrome and the aggressiveness with which the diagnosis is pursued. In Table 3 are listed a number of clinical situations in which a suspicion of ZES should be raised. The use of simple screening tests like the radioimmunoassay for serum gastrin is recommended, especially in those patients being treated with Cimetidine.

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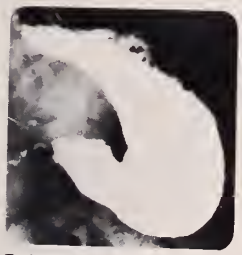

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Reference:
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Martin J. Raff, M.D., and Julio C. Melo, M.D.

WITH the influenza season rapidly approaching, it would be of interest to review the history of the current strains of influenza circulating throughout the United States. In addition, we will discuss the formulations of the vaccine currently available and provide recommendations for their use. This will allow physicians in the community to communicate with their patients and convey accurate information to them on this subject.

Systemic infection with influenza virus occurs yearly in all areas of this country. The incidence, geographic distribution, severity of the clinical illness and serologic types of influenza virus prevalent all vary greatly. Outbreaks of infection with these agents are often accompanied by excess mortality and, of course, significant added morbidity in the population-at-large. Adults and children are both affected, with the spectrum of illness ranging from mild mid-upper respiratory tract symptoms to severe pneumonia. Outcome will frequently depend upon the underlying state of health of the affected individual. Deaths occurring as a result of influenza are seen primarily among chronically ill adults and children and in individuals over the age of 65. Therefore, periodic (usually annual), vaccination is recommended for these so-called "high risk" patients.

There are two major antigenic groups of influenza virus. Type A is responsible for the majority of epidemic outbreaks of human disease and usually produces an illness of greater clinical severity than that due to type B, although influenza B infection is capable of producing fatal illness. Influenza A viruses are subtyped based upon the presence of two antigens in their substructure: hemagglutinin (H) [4 types, H0-H3] and neuraminidase (N) [2 types N1-N2]. The presence of circulating antibodies to these specific types of viral antigens confers varying degrees of immunity to this disease. Although the immune response may not always prevent the acquisition of influenza it will usually at least reduce the severity of the clinical disease. At infrequent intervals (about every 10 years), the influenza A virus prevalent in the world undergoes a major antigenic *shift*. This usually results in pandemic or world wide epidemic outbreaks as the population-at-large has no preexisting level of immunity to the new strain. During the intervening years, although the major antigenic type remains the same, there is sufficient antigenic *drift* within that subtype so that infection with one strain may not confer full immunity to infection with the antigenically altered strain. Therefore, the viral strains included in the new vaccines which are manufactured yearly are chosen to represent the organisms most prevalent at that time.

The most common form of the influenza virus that is being seen in the United States at the present time is the A-Russian 1977 strain (A/USSR/77). This particular virus has an H1 N1 antigenic structure. It was apparently first seen by the Chinese in Tsien Tsien, China in May, 1977. Unfortunately, the Chinese failed to report their outbreaks to the World Health Organization until January 11, 1978. In the interim, the virus spread to the Soviet Union. The first clinical case was recognized in Moscow on November 1, 1977 and viral isolation followed four days later. By December 5, Soviet medical authorities felt that all of the 50 major cities in the USSR which are monitored for the presence of influenza were having epidemic outbreaks. These had spread from east to west across the country. It was estimated that 7% to 10% of the entire population of the Soviet Union was infected. Of particular interest is the fact that for the most part patients above the age of 30 years were apparently spared the illness and those patients who did become infected had a relatively mild form of disease. It has been revealed retrospectively that this current strain of H1 N1 virus is probably identical to, or at least closely related to, the A/FM/1-47 (H1 N1) strain of influenza virus which was first seen in a pandemic form from 1947-1957. This helps to explain why individuals above the age of 30 were spared this illness.

The first clinical isolation of A/FM/1-47 (H1 N1) occurred in Melbourne, Australia in 1946. By December

From the Section of Infectious Diseases, Department of Medicine, and Department of Microbiology and Immunology, University of Louisville School of Medicine, Louisville, Kentucky.

Table

Influenza Vaccine* 1978-1979

Vaccine	Age	Product Type	Dosage (ml)	Number of Doses
Adult	>26 yrs.	Whole or Split virus	0.5	1
Youth	13-15 yrs.	Whole or Split virus	0.5	2+
	3-12 yrs.	Split virus	0.25	2+
	6-35 mos.++	Split virus	0.15	2+

+Doses four or more weeks apart. Two doses needed to induce adequate antibody formation.

++Based upon limited data. Since the likelihood of febrile seizures is greater in this age group, relative risks and benefits should be assessed cautiously.

*Influenza Vaccine, Trivalent, Adult Formula
Influenza Vaccine, Trivalent, Youth Formula

1946 and January 1947, outbreaks of illness due to this virus were seen at Ft. Monmouth, New Jersey. From there sporadic outbreaks were reported in schools and military encampments around the United States, and the disease became widespread and ultimately pandemic in scope. From 1950-1951 and in 1953, there were scattered outbreaks of this illness throughout the United States with a mild increase in the incidence of pneumonia due to influenza. The years 1954-1957 were relatively free of type A-influenza in the United States and there was a predominance of type B disease being seen. Therefore individuals who were exposed either clinically or subclinically to A/FM/1-47 (H1 N1), during those years, do have some levels of circulating antibody, which provides partial immunity against the current A/USSR/77 strain which is also of the H1 N1 serotype. The last known outbreaks of the H1 N1 strain, which first appeared in Melbourne, were seen in February and March of 1957 at military encampments around the United States, and until its reappearance in China in May of 1977, has not been implicated as a cause of major epidemics. From January through April, 1978, the A/USSR/77 (H1 N1) virus produced outbreaks of influenza throughout the USA in schools, colleges and to a lesser degree, among younger aged individuals in the general community. Persons over age 25 were not affected to any significant extent, presumably because of prior exposure to the H1 N1 virus that had circulated through the United States from 1947-1957.

During 1977-1978, A/Victoria/75 and A/Texas/77, both variants of A/Hong Kong/68 (H3 N2), were prevalent throughout this country. Strains of influenza B viruses, which are far more antigenically stable than influenza A viruses, remain in the general population pool. The B virus currently in circulation is antigenically similar to B/Hong Kong/72. This information provides an explanation of why there are two major formulations of vaccine currently available to the medical community (Table). Each of these two formulations contains three strains of influenza virus. The only differences between the adult and youth formulations are in the amounts of virus contained in each. These are as follows: The adult preparation (patients of the age of 26 or older) contains 7 μg of the A/USSR/77 (H1 N1) strain, 7 μg of the A/Texas/77 (H3 N2) strain, and 7 μg of the B/Hong Kong/72 strain. The A/Texas/77 (H3 N2) strain is the same as the A/Hong Kong/68 strain and the A/Victoria/75 strain except for minor antigenic drift. The formulation for youths (26 years of age and under) contains 20μg of A/USSR/77 and 7μg each of the other two strains contained in the adult preparation. Both formulations are available in either whole or split vaccines for ages 13-25 and older. For patients under the age of 13, it is recommended that only split virus vaccine be used. This is because of an increased incidence of both local and systemic side effects which occur in patients under the age of 13 when the whole virus vaccine is utilized.

As in previous years, it is recommended that all patients with potential risks of complications due to influenza receive the new vaccine so that they can be actively immunized against the current epidemic strains.

Individuals at high risk of developing adverse consequences of infection due to influenza virus should be vaccinated yearly. Such individuals include those who have:

1. Heart disease associated with altered cardio-pulmonary function, actual or potential (i.e., mitral stenosis, CHF, pulmonary hypertension, aortic stenosis, severe coronary artery disease, etc.).
2. Any disease compromising pulmonary function (i.e., COPD, chronic bronchitis, bronchiectasis, asthma, cystic fibrosis, tuberculosis, musculoskeletal or neurologic disease compromising pulmonary function, residual ventilatory dysfunction following a variety of conditions, etc.).
3. Chronic renal disease with azotemia or the nephrotic syndrome.
4. Metabolic diseases such as diabetes mellitus, hemochromatosis, hepatic cirrhosis, alcoholism, malnutrition, etc., which may predispose to or enhance susceptibility to infection.
5. Chronic severe anemia of any etiology, and
6. Immunosuppression, whether depression of fixed tissue immune response, reduced antibody formation and/or adverse quantitative or qualitative changes in neutrophil function.

Vaccination is also recommended for persons older than 65 years of age.

Side Effects and Adverse Reactions

Influenza Virus Vaccine for 1978-79 has been associated with few side effects. Local reactions, consisting of redness and induration at the site of injection lasting one or two days, have been observed in less than one-third of vaccinees. Three types of systemic reactions to influenza vaccines have been described.

1. Fever, malaise, myalgia, and other systemic symptoms of toxicity, although infrequent, occur more often in children and others who have had no experience with influenza viruses containing the vaccine antigen(s). These reactions, which begin 6-12 hours after vaccination and persist 1-2 days, are usually attributed to the influenza virus itself (even though it is inactivated), and constitute most of the side effects of influenza vaccination.

2. Immediate-presumable allergic-responses, such as flare and wheal or various respiratory expressions of hypersensitivity occur extremely rarely after influenza vaccination. They probably derive from sensitivity to some vaccine component, most likely residual egg protein. Although current influenza vaccines contain only a small quantity of egg protein, on rare occasions they can provoke hypersensitivity reactions. Individuals with anaphylactic hypersensitivity to eggs should not be given influenza vaccine. This would include persons who, upon ingestion of eggs, develop swelling of the lips or tongue or who experience acute respiratory distress or collapse.

3. Guillain-Barré syndrome (GBS) is an uncommon illness characterized by ascending paralysis which is usually self-limited and reversible. However, 5-10% of persons with GBS have residual weakness, and approximately 5% of cases are fatal. Before 1976, no association of GBS with influenza vaccination was recognized. However, that year GBS appeared in excess frequency among persons who had received swine influenza vaccine. For the 10 weeks following vaccination the excess risk was found to be approximately 10 cases of GBS for every million persons vaccinated. The overall incidence in that period was 5-6 times higher than that in unvaccinated persons. Younger persons (under 25 years) had a lower relative risk than others and also had a lower case-fatality rate. Although there is no comparable information about the association of GBS with other influenza vaccines, it must be assumed that this risk may be present for all of them. Even though the risk (in 1976) was extremely low, persons who receive influenza vaccine should be aware of it and should balance this risk against the risk of influenza and its complications.

Use in Pregnancy

Although the issue has been much discussed, only in the pandemics of 1918-19 and 1957-58 has strong evidence appeared relating influenza infections with increased maternal mortality. Although several studies have reported an increased risk of congenital malformations and childhood leukemia among children born to women who had influenza infection during pregnancy, other studies have not shown an increased risk; the issue is not settled.

Physicians prudently limit prescription of drugs and biologics for pregnant women. However, no evidence has been presented to suggest that influenza vaccination of pregnant women poses any special maternal or fetal risk. Furthermore, because influenza vaccine is an inactivated viral preparation, it does not share the theoretical risks that impel caution in the use of live virus vaccines. Taking the above uncertainties into account, physicians should evaluate pregnant women for influenza immunization according to the same chronic illness criteria applied to other persons.

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EDITORIAL

THE 128th Annual Meeting of the Kentucky Medical Association in Lexington marked the end of an unusually busy and productive Associational year. Lexington hosted the convention beautifully, with its accustomed dignified self-assurance.

John Stewart's presidency was accomplished, confident and purposeful. The time, work, diplomacy and dedication he gave were, and will be, profitable to the membership.

The House of Delegates worked long, tedious hours under Bennett Crowder's skillful, attentive leadership.

Every member of the Board of Trustees has been faithful and conscientious. Jim Holloway's chairmanship was characterized by good humor, attention to detail and efficiency. The Trustees have been considerate of their duty to the Board but, above all, have maintained an open, interested, honest communication with the members in their districts. Individually and collectively, the Board's attention to wishes of the membership has been meticulous. And in addition to a year's hard work, it is remarkably commendable that the Board has accomplished the formation of the Kentucky Medical Insurance Company in the year since it was enacted by the House of Delegates.

The KMA membership is, and should be, grateful to the Officers, Trustees and Delegates for their dedicated, hard work, given generously and with personal sacrifice.

AEO

An Investment Opportunity

PERHAPS the most unique approach ever in Professional Liability Insurance is happening in Kentucky. The KMA membership has the opportunity today to grasp control of its own destiny with more ease than perhaps physicians in any other state. Since claims and awards seem to fit a cycle pattern, it is not news that we can expect another upswing in both soon. Thus, methodically establishing our own sound company during the calm years is obviously indicated.

Why is it unique in Kentucky?

First, we have designed a mechanism to begin selling primary and excess Professional Liability Insurance coverage while proceeding to organize our own stock company vs. having to sell all of our stock before selling insurance as has been the case elsewhere. This we accomplished by chartering our own KMA Insurance Agency which has been selling insurance since June 1, 1978.

The physician-owned stock company means no more questions about an outside company's financial affairs, investments, profits, etc. Kentucky physicians will own their company and will comprise its committees. All profits realized will be returned to Kentucky physicians in the form of dividends and reduced premiums.

Historically, Kentucky has demonstrated it is a good risk state. Rather than splitting our premium income with other states which have a greater number of claims and higher awards, we can now reap whatever profits accrue through our own company. Combined with the Agency, it can produce insurance packages which will be doubly attractive.

The Kentucky Medical Insurance Company is already success oriented. We have had continuous outstanding advice from officials of PICO—the Physicians' Insurance Company of Ohio, in addition to assistance from national companies with the expertise we sought.

On October 9, 1978, Mr. Riley Lassiter became the chief executive officer of our company—KMIC. Most Kentucky physicians know Riley well and know of his expertise in Professional Liability Insurance. A native Kentuckian, he has

spent the past eighteen years with the Medical Protective Company, which has been a major writer of Professional Liability Insurance in Kentucky. Riley is joined in the day-to-day operation of KMIC by two veteran executives from the KMA staff; Don Chasteen and Shirley Roessler.

Past KMA Board Chairman, Ballard W. Cassady, M.D. of Pikeville, is KMIC's first President and Chairman of the Board. As soon as KMIC is capitalized it will write its own policies and the KMA Agency will cease to write PICO policies. That is the day we can point with pride to the fact that we have guaranteed the control over our destiny, be rated on our experience alone, and be assured a company will be in existence in Kentucky when the next crisis hits. It is an ideal investment today to insure long-range security in the market availability arena.

Don't delay in buying your stock. Your taking the initiative to get your stock purchased will save you money by eliminating the need for a formal sales campaign. Do it today.

ROBERT G. COX
KMA Executive Vice President

CHANGE OF ADDRESS

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*. Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976
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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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ASSOCIATIONAL NEWS

Drs. Howell And Bushey Named To Top KMA Offices

The KMA House of Delegates elected Robert S. Howell, M.D., Louisville, to the office of President-Elect for the 1978-79 Association year. Harold L. Bushey, M.D., Barbourville, was elected Vice President.

Doctor Howell

KMA President, Carl Cooper, Jr., M.D., Bedford, took the oath of office during the President's Luncheon on September 27. He succeeds John P. Stewart, M.D., Frankfort.

Doctor Howell, a pathologist at Jewish Hospital in Louisville, served as Vice President of KMA during 1977-78 and is a Past President of the Jefferson County Medical Society. He is a 1952 graduate of the University of Louisville School of Medicine where he now serves as Clinical Assistant Professor of Pathology and Oncology Associate. He is a member of the American Medical Association, the American Society of Clinical Pathologists and the International Academy of Pathology. Doctor Howell was president of the Kidney Foundation of Kentucky in 1974 and was for five years a director of the Episcopal Church Home.

Doctor Bushey, an internist, is the immediate Past Vice-Chairman of the KMA Board of Trustees, having served as Trustee from the Fifteenth District since 1972. Doctor Bushey has practiced internal medicine in Barbourville since 1959. He is active in numerous professional and civic organizations, and was named "Outstanding Citizen of the Year" by the Knox County Chamber of Commerce in 1973. An Illinois native, he completed his M.D. degree at the Rochester Medical School, Rochester, New York in 1954.

Doctor Bushey

Bennett L. Crowder, II, M.D., Hopkinsville, and Peter C. Campbell, Jr., M.D., Louisville, were reelected Speaker and Vice Speaker, respectively. Doctor Crowder, a general and thoracic surgeon, has previously served as Vice Speaker and Parliamentarian. Doctor Campbell, an ophthmologist, has served for several years on the KMA Scientific Program Committee.

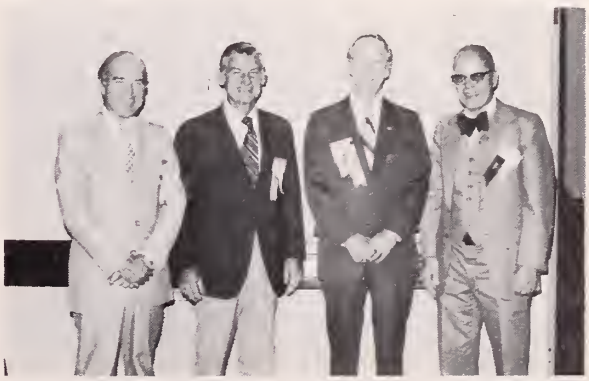
Reelected to a two-year term as Delegates to the American Medical Association was Harold D. Haller, Sr., M.D., Louisville. Other AMA Delegates are David B. Stevens, M.D., Lexington and Fred C. Rainey, M.D., Elizabethtown. Kenneth P. Crawford, M.D., Louisville, was reelected Alternate ATA Delegate. Other Alternate Delegates are Lee C. Hess, M.D., Florence and Wally O. Montgomery, M.D., Paducah.

Trustees Name Dr. Watkins and Dr. Blackburn to Head Board

William T. Watkins, M.D., Somerset, Twelfth District Trustee since 1974, was elected Chairman of the KMA Board of Trustees for 1978-79. Doctor Watkins succeeds James B. Holloway, Jr., M.D., Lexington. Dwight L. Blackburn, M.D., Berea, was named Vice Chairman.

Doctor Watkins, a pediatrician, has served as Chief of Pediatrics and Chief of the Medical Staff at Somerset City Hospital. He is a voluntary assistant professor of pediatrics at the University of Kentucky Medical Center, Lexington. He is a member of both the Pulaski County Medical Society and the Kentucky Chapter of Pediatrics.

Doctor Blackburn, a Trustee from the Eleventh District since 1975, is in family practice in Berea, and is a past president of the Madison County Medical Society. He is active in the Lions Club, the Chamber of Commerce and the Berea College Board of Trustees.



KMA officers for 1978-79 are (left to right): S. Randolph Scheen, M.D., Louisville, Secretary-Treasurer; Robert S. Howell, M.D., Louisville, President-Elect; Carl Cooper, Jr., M.D., Bedford, President; and Harold L. Bushey, M.D., Barbourville, Vice President.

Newly-elected members of the KMA Board of Trustees are: Walter S. Coe, M.D., Louisville, Fifth District; Richard F. Hench, M.D., Lexington, Tenth District; and Donald C. Barton, M.D., Corbin, Fifteenth District.

Reelected to three-year terms are: Earl P. Oliver, M.D., Scottsville, Sixth District; Richard J. Menke, M.D., Crestview Hills, Eighth District; and Dwight L. Blackburn, M.D., Berea, Eleventh District.

Alternate Trustees to the Board are: Glenn W. Bryant, M.D., Louisville, Fifth District; L. Martin Wilson, M.D., Bowling Green, Sixth District; R. E. Smith, M.D., Covington, Eighth District; Don E. Cloys, M.D., Richmond, Eleventh District; and Emanuel Rader, M.D., Pineville, Fifteenth District.

Meeting Highlights of the KMA House of Delegates

The December, 1978, issue of *The Journal* will contain the complete proceedings of the House of Delegates meeting, but the following is a brief outline of some of the major activities that took place.

During the first session of the House, on September 25, the Chairman of the AMA Board of Trustees, Robert B. Hunter, M.D., spoke of areas in which AMA is now active. He stated that under the auspices of the AMA Council on Medical Services, and as a result of a three-to-five year campaign, the AMA now has its largest house staff and student membership.

Doctor Hunter said there are 68,000 foreign medical graduates now residing in this country who are not members of organized medicine, and that a new advisory committee has been established to attempt to recruit them.

Regarding National Health Insurance, Doctor Hunter called for the continuance of current modes of practice, stating AMA's strong opposition to any NHI which would drastically change the system. Doctor Hunter further pointed out that if an NHI proposal is enacted, regardless of which version it might be, the country will be faced with a minimum additional expenditure for health care of $19 billion.

Doctor Hunter also discussed AMA's legal actions relating to the Federal Trade Commission, chiropractors, and others.

The House recognized Kentucky's own Hoyt D. Gardner, M.D., the new President-Elect of the AMA.

During the final session of the House, several reports and resolutions were considered and major actions included were:

- Voted legislative opposition to inflationary and unnecessary radiology requirements.
- Voted support of the newly-formed Kentucky Medical Insurance Company, KMA's own captive liability insurer.
- Endorsed the call of AMA President, Tom E. Nesbitt, M.D., to moderate fee increases and endorsed the Voluntary Effort for cost containment.
- Voted opposition to setting minimum obstetrical services or hospital occupancy rates for facilities to continue operation.
- Voted a dues change for new physicians as a membership incentive.

KMA Award recipients receive congratulations from KMA officers. They are (left to right): John C. Quertermous, M.D., Murray, who received the KMA Distinguished Service Award; John P. Stewart, M.D., Frankfort, Immediate Past President; Joe D. Miller, Deputy Executive Vice President and Senior Vice President of the American Medical Association, who received the Kentucky Medical Association Award; Carl Cooper, Jr., M.D., Bedford, President; and Fred C. Rainey, M.D., Elizabethtown, Chairman of the KMA Awards Committee.

Dr. Quertermous And Mr. Miller Receive 1978 KMA Awards

KMA presented its highest awards to John C. Quertermous, M.D., Murray, and Joe D. Miller, Chicago, Illinois, during the 1978 Annual Meeting. Fred C. Rainey, M.D., Elizabethtown, Chairman of the KMA Awards Committee, made the presentation at the President's Luncheon on September 27, at the Lexington Convention Center, Lexington.

Doctor Quertermous, who received the Distinguished Service Award, was described by Doctor Rainey as "an able clinician, a concerned practitioner, a physician dedicated to the ideals of organized medicine, and also, quite simply, a good man." Doctor Quertermous' present position as President of the State Board of Medical Licensure is, Doctor Rainey said, "a culmination of an entire professional life spent in commitment to health and the practice of medicine. Doctor Rainey characterized Doctor Quertermous' tenure at the Licensure Board as having "developed a stature of integrity and aggressiveness in implementing those procedures necessary to maintain the competence and quality of the physicians of our state."

Joe D. Miller, who received the Kentucky Medical Association Award, is Deputy Executive Vice President and Senior Vice President of the American Medical Association. He was honored for his "contribution to our federation and our profession during his career with the AMA." Born in Smith Grove, Kentucky, Mr. Miller is a graduate of the University of Kentucky. Before joining the AMA in 1957, he served as Executive Director of the Kentucky Tuberculosis Hospital Commission in Kentucky. Since he joined the AMA as a research associate, Mr. Miller has served as executive director of the American Medical Political Action Committee (AMPAC), as well as public affairs officer. In presenting the KMA Award, Doctor Rainey commended Mr. Miller for "his commitment to the free enterprise system and the best of American medicine . . ."

Delegates Choose Members for 1979 Nominating Committee

Five physicians were elected by the House of Delegates at its final session on September 27 to serve on the 1979 Nominating Committee.

Committee members for 1979 are: W. Bruce Hamilton, M.D., Shepherdsville, Chairman; William E. Becknell, M.D., Manchester; Glenn U. Dorroh, M.D., Lexington; Charles R. Oberst, M.D., Louisville; and W. Eugene Sloane, M.D., Paducah.

The Committee is responsible for presenting a slate of candidates for all elective offices within the structure of KMA to the House of Delegates at the 1979 Annual Meeting.

1646 Attend KMA 1978 Meeting

One thousand, six hundred and forty-six people registered for the 1978 KMA Annual Meeting in Lexington. Although registration figures reflected a slight decrease from previous years, it is felt that another 300 people participated in some phase of the meeting, but did not register. The physical layout of the Convention Center, an unavoidable conflict with a large national specialty society, and the lack of additional housing near the Hyatt Regency were contributing factors. In addition, the Auxiliary to KMA now holds its Annual Meeting in the spring, due to space limitations, rather than during KMA's meeting.

General scientific and specialty groups' sessions were well attended, as were both meetings of the House of Delegates. The 1979 Annual Meeting is scheduled for September 23-27, at the Ramada Inn/Bluegrass Convention Center, Louisville.

Members in the news

NEW MEMBERS

BELL
Fazal Siddiqui, M.D., Pineville

CAMPBELL-KENTON
Vincent E. Ziegler, M.D., Crestview Hills

CLAY
William E. Becknell, Jr., M.D., Manchester
Barry Wecker, M.D., Manchester

FAYETTE
James A. Bottiggi, M.D., Lexington
John M. Fox, M.D., Lexington
Neven J. Gardner, M.D., Lexington
Phillip H. Hoffman, M.D., Lexington
Ronald L. Humphrey, M.D., Lexington
L. Raymond Reynolds, M.D., Lexington
Thomas K. Slabaugh, M.D., Lexington
Richard F. Smith, M.D., Lexington
Thomas T. Tucker, M.D., Lexington
Alexander L. Vigh, M.D., Lexington
Jerry L. Yon, M.D., Lexington

JEFFERSON
Kenneth M. Beilman, M.D., Louisville
Charles O. Bruce, III, M.D., Louisville
Joseph R. Cecil, Jr., M.D., Quantico, Va.
Robert W. Copley, II, M.D., Evansville, Ind.
Gary L. Fuchs, M.D., Louisville
Thomas M. Loeb, M.D., Louisville
Richard A. Mitchell, M.D., Louisville
Tamara Smith, M.D., Louisville
David H. Winslow, M.D., Louisville

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

OCTOBER

4-6	Officers-Staff Conference, Louisville
10	*Journal* Editors, Louisville
25	KMA Executive Committee, Louisville

NOVEMBER

6	Ad Hoc Committee on Hospital-Based Specialists, Louisville
7-8	AMA-AHA-FAH Voluntary Effort Program, Chicago, Ill.
9	Physicians Health Committee, Louisville
9-11	National Joint Practice Conference, Dallas, Tex.
14	*Journal* Editors, Louisville
23-24	Office Closed
28	KMA-KNA Joint Practice, Louisville
30	Board of Medical Licensure, Louisville

Gov. Julian M. Carroll addresses the guests at the KMA President's Luncheon, September 27.

Was Your Delegate Present?
ROLL CALL —
1978 House of Delegates
KMA Annual Meeting

OFFICERS

		First Session	Second Session
Speaker	Bennett L. Crowder, II	Present	Present
Vice Speaker	Peter C. Campbell, Jr.	Present	Present
President	John P. Stewart	Present	Present
President-Elect	Carl Cooper, Jr.	Present	Present
Vice-President	Robert S. Howell	.....	Present
Secretary-Treasurer	S. Randolph Scheen	Present	Present
Delegate to AMA	Harold D. Haller, Sr.	Present	Present
Delegate to AMA	Fred C. Rainey	Present	Present
Delegate to AMA	David B. Stevens	Present	Present
Alternate Delegate to the AMA	Kenneth P. Crawford	Present	Present
Alternate Delegate to the AMA	Wally O. Montgomery	Present	Present
Alternate Delegate to the AMA	Lee C. Hess	.....	Present

TRUSTEES

District			
First	Wally O. Montgomery	Present	Present
Second	R. J. Phillips	Present	Present
Third	Frank R. Pitzer	Present	Present
Fourth	Charles B. Spalding	.....	.....
Fifth	Cecil L. Grumbles	Present	Present
Sixth	Earl P. Oliver	Present	Present
Seventh	William H. Keller	Present	Present
Eighth	Richard J. Menke	Present	Present
Ninth	Don R. Stephens	.....	.....
Tenth	James B. Holloway, Jr.	Present	Present
Eleventh	Dwight L. Blackburn	Present	Present
Twelfth	William T. Watkins	Present	Present
Thirteenth	Howard B. McWhorter	.....	Present
Fourteenth	Harvey A. Page	.....	.....
Fifteenth	Harold L. Bushey	Present	Present

ALTERNATE TRUSTEES

District			
First	James E. Adams	.....	.....
Second	Albert H. Joslin	Present	Present
Third	Henry R. Bell	.....	.....
Fourth	Terrell D. Mays	.....	.....
Fifth	Glenn W. Bryant	Present	Present
Sixth	Martin Wilson, Jr.	Present	Present
Seventh	William Powers	.....	.....
Eighth	Robert C. Smith	.....	.....
Ninth	Kelly G. Moss	.....	.....
Tenth	Richard F. Hench	Present	Present
Eleventh	Don E. Cloys	Present	Present
Twelfth	Danny M. Clark	Present	Present
Thirteenth	George R. Bellamy	.....	.....
Fourteenth	Jerry D. Fraim	.....	.....
Fifteenth	Walter H. Stepchuck	Present	Present

PAST PRESIDENTS

Past President	Paul J. Parks	Present	Present
Past President	David A. Hull	Present	Present
Past President	Hoyt D. Gardner	.....	Present
Past President	Fred C. Rainey	Present	Present
Past President	Lee C. Hess	.....	Present

DELEGATES

FIRST DISTRICT

		First Session	Second Session
BALLARD			
CALLOWAY	R. Gary Marquardt	Present	Present
CARLISLE			
FULTON	Andrew P. Nelson	Present	Present
GRAVES	Donald C. Haugh	.....	.....
	C. Douglas Leneave (Alt.)	Present	.....
HICKMAN	C. J. Mills	.....	.....
LIVINGSTON	Stephen Burkhart	.....	.....
MCCRACKEN	James C. Embry (Alt.)	Present	Present
	Larry C. Franks	Present	Present
	William Jackson	Present	Present
	W. Eugene Sloane	Present	Present
MARSHALL	Keith Ellis	Present	Present

SECOND DISTRICT

DAVIESS	James Baumgarten	Present	Present
	R. Glenn Green	Present	Present
	Albert H. Joslin	Present	Present
	Donald R. Neel	Present	Present
HANCOCK	B. Presley Smith, II	.....	Present
HENDERSON	Kenneth M. Eblen	.....	.....
	John W. McClellan	Present	Present
	C. J. McGruder (Alt.)	.....	Present
MCLEAN	John L. Patton (Alt.)	Present	Present
	Hugh H. Wilhite	.....	.....
OHIO	Robert E. Norsworthy	.....	.....
UNION			
WEBSTER			

THIRD DISTRICT

CRITTENDEN	Westel L. Creager	.....	.....
HOPKINS	Herbert Chaney	Present	Present
	C. R. Dodds	.....	Present
PENNYRILE MULTI-COUNTY SOCIETY			
CALDWELL	N. H. Talley	Present	Present
CHRISTIAN	Carl Caplinger	Present	Present
	Delmas M. Clardy	Present	Present
	James Howard Simpson	.....	.....
LYON	Alex A. Zegarra	Present	Present
MUHLENBERG	William L. Miller	.....	.....
	James S. Brashear	Present	Present
TODD	Larry O. Brock	Present	Present
TRIGG	George F. Brockman (Alt.)	.....	Present
	Eduardo Pavon	.....	.....

FOURTH DISTRICT

BRECKINRIDGE	Carl Buchele	.....	Present
	James Sills	.....	.....
BULLITT	W. B. Hamilton	Present	Present
GRAYSON	Charles L. Bland	.....	.....
GREEN	Kenneth J. De Simone	.....	Present
HARDIN	W. M. Hall	Present	Present
	L. Y. Moreman	.....	.....
HART	Keene M. Hill	Present	Present
LARUE	Marion A. Douglass, Jr.	.....	Present
MARION	John W. Ratliff	Present	Present
MEADE	Walter A. Cole	.....	.....
NELSON	Kenneth L. Stinnette	.....	.....
TAYLOR	Henry F. Chambers	.....	.....
	Forest Shely (Alt.)	Present	Present
WASHINGTON	Dixie E. Snider	.....	Present

FIFTH DISTRICT

JEFFERSON	William Steve Aaron	.....	Present
	Hugh P. Adkins	Present	Present
	Joseph C. Babey	.....	Present
	David Bizot	.....	Present
	Harold Blevins	Present	Present
	Joseph R. Bowling	.....	Present
	Charles Brohm	Present	Present
	Glenn Bryant	Present	Present
	John Bunting	.....	Present
	E. Dean Canan (Alt.)	Present	Present
	James Childers	Present	Present
	Ronald N. Collier	.....	Present
	Eugene H. Conner	.....	Present
	Clinton C. Cook, III	.....	Present
	Samuel L. Cooper (Alt.)	.....	Present
	Thomas C. Dedman	Present	Present
	Donne DeMunbrun	Present	Present
	Bob M. DeWeese	.....	Present
	John M. Farmer	Present	Present
	Paul A. Fleitz	.....	Present
	Michael B. Flynn	Present	.....
	James W. Forrester	Present	Present
	Henry Garretson	.....	Present
	John S. Harter (Alt.)	.....	Present
	C. C. Hazlett (Alt.)	.....	Present
	Homer A. Holt, Jr.	.....	Present
	Walter I. Hume, Jr.	.....	Present
	Richard Jelsma	.....	.....
	Ferrell C. Lowrey, Jr.	.....	.....
	Theodore N. Lynch	Present	Present
	Edward N. Maxwell	Present	Present
	James P. Moss	.....	Present
	Charles R. Oberst	.....	Present
	C. Kenneth Peters	.....	.....
	C. Ray Potts	.....	Present
	Carroll H. Robie	Present	Present
	Gradie R. Rowntree (Alt.)	.....	Present
	Charles C. Smith, Jr.	Present	Present
	Thomas Stigall	Present	Present
	David E. Townes	.....	Present
	Donald Varga	Present	Present
	Samuel D. Weakley	Present	Present
	A. Franklin White	Present	Present
	William E. Yancey	Present	Present

SIXTH DISTRICT

ADAIR	Millard C. Loy	Present	.....
ALLEN	Earl P. Oliver	Present	Present
BARREN	Howard Edgin	.....	.....
BUTLER	Richard T. C. Wan	Present	Present
CUMBERLAND	Samuel L. Rice	Present	Present
EDMONSON	Sydney E. Farmer	.....	.....
LOGAN	C. V. Dodson	Present	Present
METCALFE	Lawrence P. Emberton	Present	.....
MONROE	William R. Bushong	Present	.....
SIMPSON	J. Michael Pulliam	Present	Present
WARREN	John Blackburn	Present	Present
	John Downing	Present	Present
	Martin Wilson	Present	Present

SEVENTH DISTRICT

ANDERSON	H. Boyd Caudill	.....	.....
CARROLL	Cecil Martin	Present	Present
FRANKLIN	Harry J. Cowherd	Present	Present
	David L. Douglass	Present	Present
	O. M. Patrick	Present	Present
GALLATIN			
GRANT	Michael Goodman	.....	.....
HENRY	Wyatt Norvell	Present	Present
OLDHAM	Robert G. Wellman	Present	Present
OWEN	O. A. Cull	.....	.....
SHELBY	Willis P. McKee	Present	Present
SPENCER	William K. Skaggs	.....	Present
TRIMBLE	Carl Cooper, Jr.	Present	Present

EIGHTH DISTRICT

BOONE	William M. Waller	Present	Present
	William R. Yates	Present	Present
CAMPBELL-KENTON	Richard Allnutt (Alt.)	Present	Present
	Carl Brueggemann	.....	.....
	Thomas L. Heavern (Alt.)	Present	Present
	Howard Heringer, Jr.	Present	Present
	Paul H. Klingenberg	Present	Present
	William B. Monnig	Present	Present
	Robert E. Smith	Present	Present
	Fred A. Stine	Present	Present
	Raymond J. Timmerman	.....	.....

NINTH DISTRICT

BATH	Robin A. Byron	.....	.....
BOURBON	Alfred V. Echiverri	.....	.....
BRACKEN	James M. Stevenson	.....	.....
FLEMING	Robert W. Fidler	.....	Present
HARRISON	A. C. Wright	Present	Present
MASON	Joseph E. McKenney	Present	Present
NICHOLAS	Allen J. Hamon	.....	.....
PENDLETON	Robert L. McKenney	Present	.....
ROBERTSON			
SCOTT	Gus A. Bynum	Present	Present

TENTH DISTRICT

FAYETTE	Leslie W. Blakey	Present	Present
	Walter R. Brewer	.....	.....
	P. Raphael Caffrey	.....	Present
	D. Kay Clawson	Present	Present
	Marcus L. Dillon, Jr.	.....	Present
	Glenn U. Dorroh	Present	Present
	Harold T. Faulconer (Alt.)	.....	Present
	Ward O. Griffen, Jr.	Present	.....
	Allen E. Grimes, Jr.	Present	Present
	Ronald D. Hamilton	Present	Present
	Walter D. Harris	Present	Present
	Thomas M. Jarboe (Alt.)	.....	Present
	Edgar M. McGee	Present	Present
	Franklin B. Moosnick	Present	Present
	Charles H. Nicholson	Present	Present
	Edwin J. Nighbert	Present	.....
	Dennis B. Penn	Present	Present
	John D. Perrine	Present	Present
	Ellsworth C. Seeley (Alt.)	.....	Present
	John E. Trevey	Present	Present
JESSAMINE	Phyllis J. Corbitt	Present	Present
WOODFORD	Lewis E. Wash	Present	Present

ELEVENTH DISTRICT

CLARK			
ESTILL			
JACKSON	Philip R. Curd	.....	.....
LEE	Arnold L. Taulbee	.....	.....
MADISON	Don E. Cloys	Present	Present
	Linda S. Fagan	Present	Present
MENIFEE			
MONTGOMERY			
OWSLEY	Carl W. Noble	.....	.....
POWELL			
WOLFE	Paul F. Maddox	.....	.....

TWELFTH DISTRICT

BOYLE	Elmer H. Jackson	Present	Present
	David C. Liebschutz	Present	Present
CASEY	Lewis E. Wesley	Present	Present
CLINTON	Floyd B. Hay	Present	Present
GARRARD	Paul J. Sides	.....	Present
LINCOLN	Charles C. Crase	Present	.....
McCREARY	H. A. Perry	.....	.....
	John A. L. Paton (Alt.)	Present	Present
MERCER	Bacon R. Moore, III	Present	Present
PULASKI	Veryl Frye	Present	Present
	Danny M. Clark (Alt.)	Present	Present
ROCKCASTLE	George W. Griffith	.....	.....
RUSSELL	Charles E. Peck	.....	.....
WAYNE	John W. Simmon	.....	.....
	Robert B. Breeding	.....	Present

THIRTEENTH DISTRICT

BOYD	John Harrison (Alt.)	.....	Present
	J. Marvin Keeton	.....	Present
	Wiley Kozee	Present	Present
	Paul Lett	Present	.....
CARTER			
ELLIOTT			
GREENUP			
LAWRENCE			
LEWIS			
MORGAN	James D. Frederick	.....	.....
ROWAN	Raymond Mecca	Present	Present
	David Harris (Alt.)	Present	.....

FOURTEENTH DISTRICT

BREATHITT	Robert B. Chambliss (Alt.)	.....	Present
	H. Price Sewell, III	.....	.....
FLOYD	W. Grady Stumbo	Present	Present
JOHNSON	Joseph H. Rapier, Jr.	Present	.....
KNOTT	Gene T. Watts	.....	.....
LETCHER	Vincent C. Arroz	Present	Present
MAGOFFIN			
MARTIN	Raymond D. Wells	.....	.....
PERRY	Donnie R. Spencer	.....	.....
PIKE	Charles G. Nichols	Present	Present
	Terry L. Wright	Present	Present

FIFTEENTH DISTRICT

BELL	J. B. LeSage	Present	Present
	Emanuel H. Rader	Present	Present
CLAY	W. E. Becknell	.....	.....
HARLAN	Milo H. Schosser	Present	Present
	Paul W. Walstad	Present	Present
KNOX	Rofino F. Crisostomo	Present	Present
LAUREL	William D. Pratt	Present	Present
LESLIE	W. B. R. Beasley	Present	Present
WHITLEY	R. D. Pitman	Present	Present
	Donald C. Barton	Present	Present

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 25 and 27.

Did you know . . .

The Board of Trustees of the University of Kentucky has named David C. Schmauss executive director of the University of Kentucky Hospital. Mr. Schmauss, formerly of Philadelphia, was for the past four years vice president and general director of the northern division of the Albert Einstein Medical Center in Philadelphia. He also served as vice president for programs for the Appalachian Regional Hospitals, Inc. (ARH), serving Kentucky, West Virginia and Virginia, and was administrator of the Appalachian Regional Hospital in Beckley, West Virginia from 1968 to 1974.

In a statement to the press issued shortly after HEW formally announced the start of its surgical second-opinion program, AMA Executive Vice President James H. Sammons, MD, warned that the program "promises to increase utilization of physician services as Medicare and Medicaid patients across the country are urged to seek a second-opinion before all nonemergency surgery." Dr. Sammons refuted HEW's claim that its national second-opinion program would be cost reducing. Short-term results of several experimental second-opinion programs "have not provided clear evidence," he said, "that a national program of this type will either improve the quality of care or reduce health cost."

Southern Optical

LOUISVILLE	Southern Optical Bldg.	640 River City Mall	583-0687
	Medical Towers Bldg.	Floyd & Gray	582-1119
	Doctors Office Bldg.	Liberty at Floyd	583-7909
	Medical Arts Bldg.	1169 Eastern Parkway	452-2332
	Highland Professional Plaza	810 Barret Ave.	584-7934
	Professional Bldg. East	3101 Breckinridge Lane	459-0133
	Medix Bldg.—Adj. S.S. Mary & Elizabeth Hosp.		367-2277
	Broadway Bldg.	224 E. Broadway	583-7137
ST. MATTHEWS	313 Wallace Avenue		895-9155
	108 McArthur Drive		895-3855
	901 Dupont Road at Breckinridge Lane		897-3264
NEW ALBANY	Professional Arts Bldg.	1919 State Street	945-2802
BOWLING GREEN	Greentree Shopping Ctr.	900 Fairview Ave.	843-6556
OWENSBORO	Doctors Bldg.	1001 Center Street	684-1508
	Lincoln Professional Ctr.	2816 Veach Road	685-4725
GLASGOW	Happy Valley Center	409 Happy Valley Rd.	651-5113

HEARING AIDS

Louisville	638 River City Mall • 901 Dupont Rd.
New Albany	Professional Arts Bldg. • 1919 State St.
Bowling Green	900 Fairview Avenue
Owensboro	Lincoln Professional Ctr. • 2816 Veach Rd.

CONTACT LENSES

Louisville	640 River City Mall • 108 McArthur Dr. 3101 Breckinridge Lane
Bowling Green	900 Fairview Avenue
Owensboro	Doctors Bldg. • 1001 Center St.

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ARE YOU A *NATURAL* FOR AMWA MEMBERSHIP?

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YOU ARE if you are a medical communicator who wants to know and use the best contemporary verbal/visual techniques for conveying information.

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YES I want to know more about AMWA

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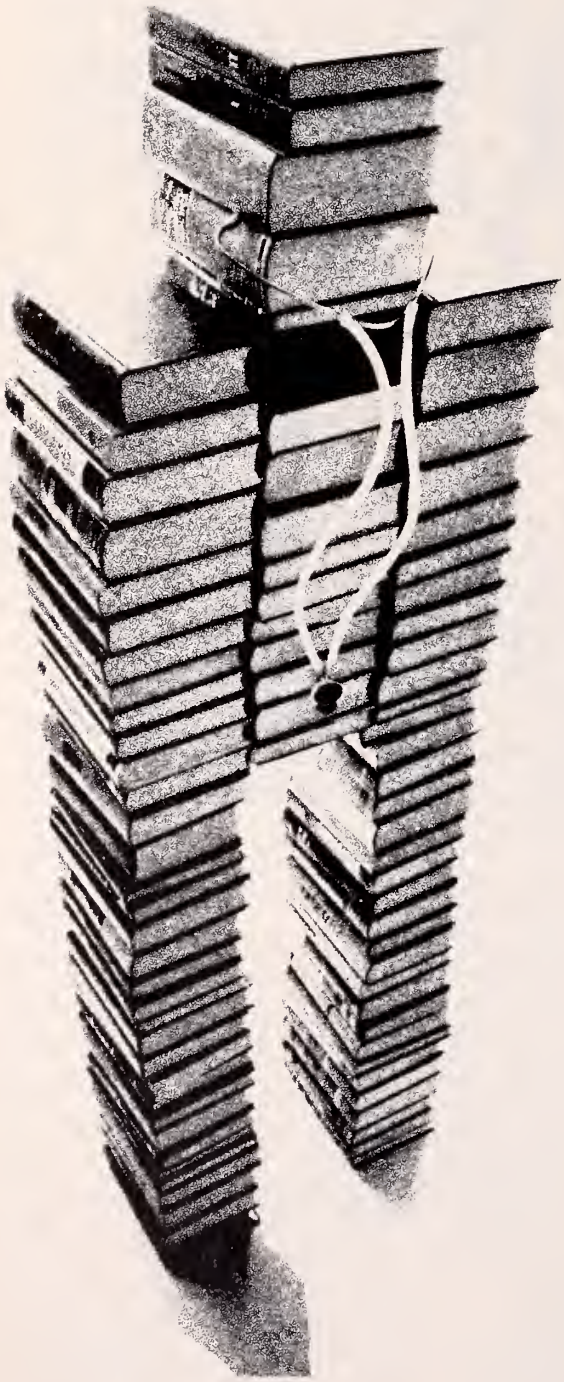
AMERICAN MEDICAL WRITERS ASSOCIATION

Anatomy of a Doctor.



You know what it takes to make a doctor. The motivation. The years of study and training. The dedication. The hard work.

But from the criticism leveled at doctors lately you'd think neither the public nor press had any idea.

It may surprise you, but the public does.

This was evidenced in a recent Harris Poll. In measuring public respect for U.S. leadership, it showed a drastic drop in the past five years. And "a majority of Americans is currently willing to express a 'great deal of confidence' in only one profession—medicine—on a list covering 16 types of activity." And that list included Congress and the Supreme Court.

People still look at their doctors as men to be respected and as men of integrity.

This is the true story of the American doctor. And one which the AMA is constantly telling the public as part of its communications program.

In newspapers and magazines, the AMA tells what it takes to be a doctor. American medicine's achievements. And to express the profession's concern by providing information to help every American lead a healthier life.

We can be an even more effective spokesman...with your support. Find out more about what the AMA does for you and the public. Send for a free pamphlet. Write: Dept. DW, at the address below.

JOIN US.
WE CAN DO MUCH MORE TOGETHER.

American Medical Association
535 North Dearborn Street/Chicago, Illinois 60610

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE

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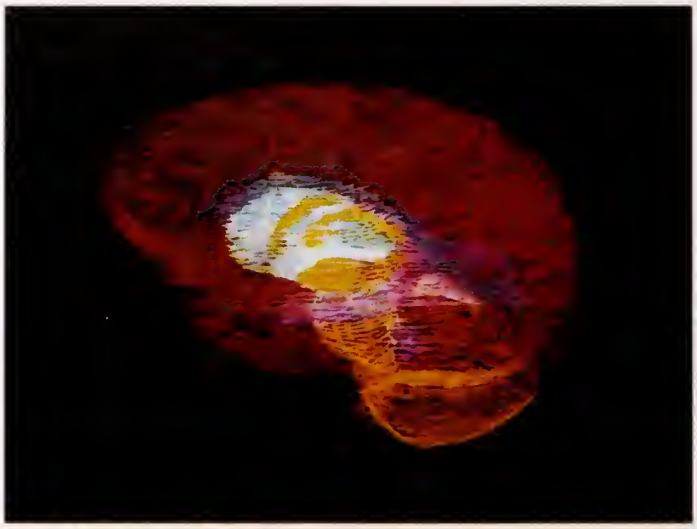
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ONLY VALIUM® (diazepam) GIVES YOU THIS CHOICE OF DOSAGE FORMS AND FLEXIBILITY



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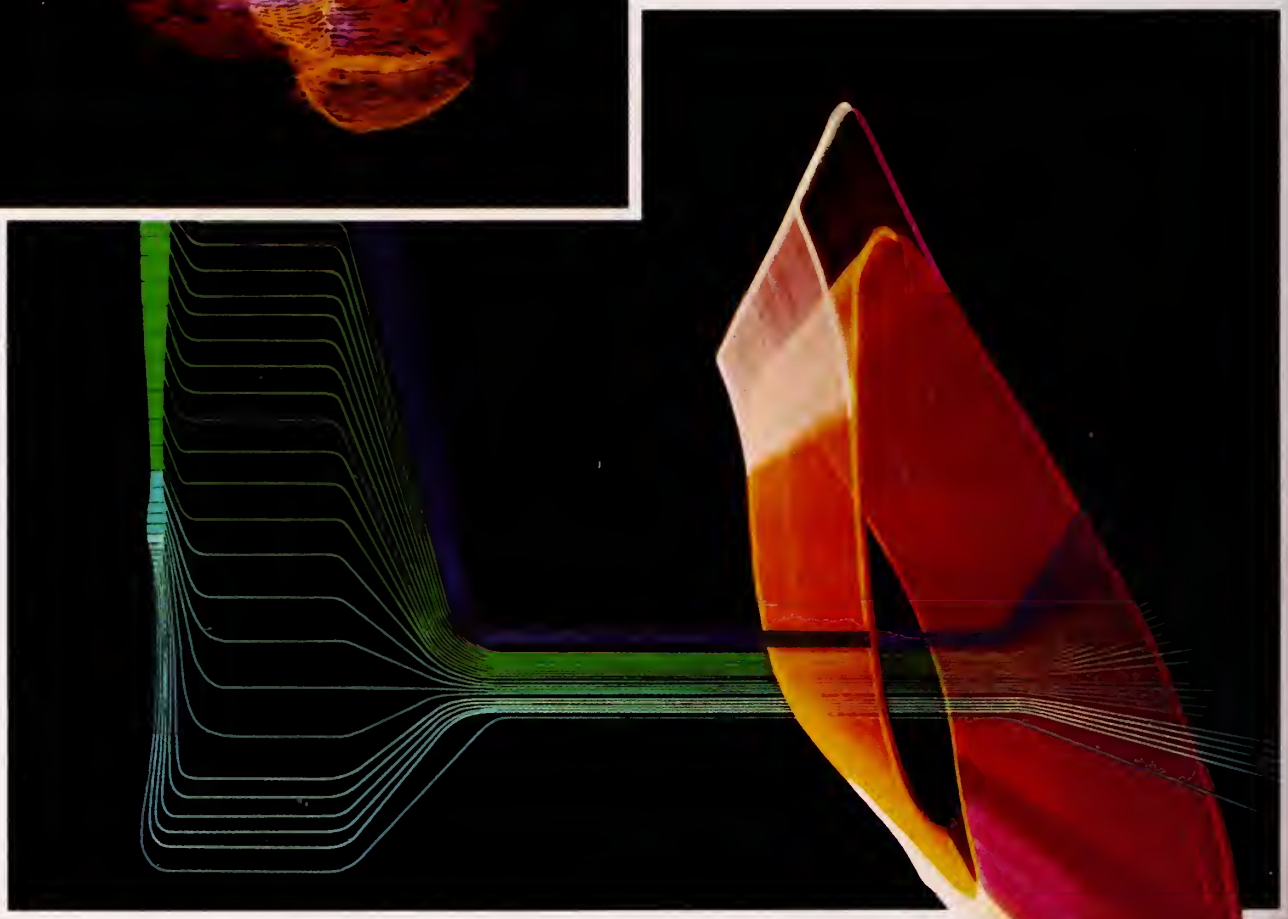

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December 1978
Volume 76
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In This Issue:
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The Journal Of The Kentucky Medical Association

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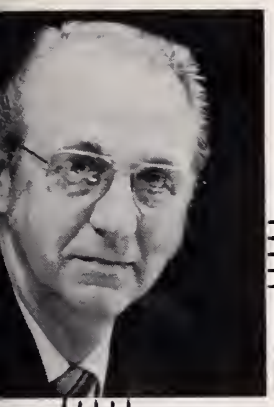

IN late 1977, Representative Dan Rostenkowski (D-Ill), issued a challenge to the health care industry to develop a voluntary program to hold the line on the escalation of health costs. The AMA, the American Hospital Association and Federation of American Hospitals responded by establishing the Voluntary Effort. Designed to lower the rate of inflation in hospital costs by a national average of two percentage points per year, the Voluntary Effort has reduced that rate of increase in the first eight months of 1978 by three percent. The success of the National Voluntary Effort was singled out as the most important factor in the defeat of the Administration's Cost Containment Proposal during the 95th Congress. Proponents of the measure will reintroduce it in the 96th Session.

The Kentucky Voluntary Effort for Cost Containment was established by KMA and the Kentucky Hospital Association to reach the goals developed nationally. Every hospital administrator, medical staff president, and county medical society has been asked to support this undertaking.

A recent report by Kentucky Blue Cross and Blue Shield indicates that there has been a reduction in Kentucky in the rate of increase both in hospital costs and physician charges during the first six months of 1978. By merely extending an existing trend, medicine can demonstrate a very visible and extremely persuasive argument in our struggle to preserve our pluralistic medical care system which emphasizes voluntary problem solving by the private sector.

It is vital that the individual physician continue to be a leader in this effort. There is no limit to what we can do through a united effort. I urge each of you to participate collectively to help reduce the rate of hospital cost increases by two percent per year and individually to reduce the rate of increase of your professional fee by one percent per year, as recommended by the KMA House of Delegates.

Take time to explain how patients can improve their health by modifying life styles and the consequences of the inappropriate use of facilities and insurance coverage.

If we truly do not want government to control the practice of medicine, the best way to prevent it is by visible, workable, voluntary programs. The Interim Joint Committee on Health and Welfare of the Kentucky General Assembly recently held the first of a series of meetings on cost containment. We can be sure that the issue of health costs will be of continuing interest to our legislators for some time to come.

Carl Cooper, Jr., M.D.
KMA President

Auxiliary

A Link in the Chain

The Auxiliary to KMA is vitally interested in the future of medicine in this country and the betterment of medical education. Our joint efforts—as physicians and spouses—in the American Medical Association Education and Research Foundation program help to eliminate the financial barrier to medicine for all who are qualified and accepted by an approved training institution. This Loan Program for medical students, interns, and residents is the result of a cooperative effort by American medicine and private enterprise.

This Auxiliary page is a Christmas greeting from those who have contributed this year to our Sharing Card for AMA-ERF. This list does not include additional contributions received after November 22.

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Complete literature available on request from Professional Services Dept. PML.

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7 Renal Failure—Pathophysiology and Management.** Hyatt Regency, Louisville

JANUARY, 1979

11 Lecture on Bone Radiology by Freida Feldman, M.D., Guest Lecturer for Bluegrass Radiological Society, Albert B. Chandler Medical Center, Lexington. Contact James G. Lorman, M.D., Dept. of Diagnostic Radiology, U of Ky., Lexington, Ky. 40506

FEBRUARY, 1979

8 Lecture on neuroradiology*** by Glen H. Roberson, M.D., Guest Lecturer for Bluegrass Radiological Society, Albert B. Chandler Medical Center, Lexington, Ky.

23-24 Symposium on Psychopharmacology*, Health Sciences Center, University of Louisville School of Medicine.

MARCH, 1979

5-9 Practical Microsurgery Symposium and Workshop**

8 Bluegrass Radiological Society Lecture***, "Pediatric Radiology." Armand E. Brodeur, M.D., Cardinal Glennon Memorial Hospital, St. Louis, Mo. (Lecture in Lexington.)

9 C. Dwight Townes Memorial Seminar**

9-11 Advanced Cardiac Life Support**

29 Common Skin Disorders**

APRIL, 1979

23-26 Surgical Anatomy**

26-28 High Risk Pregnancy**

26-30 Modern Management of Major Problems in Surgery**

OCTOBER, 1979

20 Kentucky Regional Meeting, American College of Physicians, Hyatt House, Louisville.

IN SURROUNDING STATES

FEBRUARY, 1979

14-15 "Frontiers in Medical Ethics." Vanderbilt University School of Medicine, Nashville, Tenn. Contact: Marilyn Short, Div. of Continuing Education, Vanderbilt University, Nashville, Tenn. 37203.

APRIL, 1979

9-11 Conference on Neuromotor Speech Disorders in Adults and Children, University of Cincinnati Medical Center, Div. of Audiology & Speech Pathology. Contact: Dorothy H. Air, Div. of Audiology & Speech Pathology, University of Cincinnati Medical Center, 234 Goodman Street, Pav. A-122, Cincinnati, O. 45267.

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***For further information contact: Gerald D. Swim, Executive Director, Office of Continuing Education, University of Louisville School of Medicine, Louisville 40202*

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VOLUME 76 DECEMBER 1978 NUMBER 12

Malignant Melanoma: Current Perspectives With Emphasis Upon Treatment According to Prognosis

Hiram C. Polk, Jr., M.D.
Louisville, Kentucky

Malignant melanoma is an uncommon tumor associated with a reasonably favorable prognosis and warrants treatment in an organized, integrated manner. The keystone of treatment is early diagnosis by biopsy and adequate local excision of the primary melanoma. The usefulness of various adjunctive therapeutic maneuvers remains to be determined. Current consensus holds that aggressive treatment for unfavorable melanomas is appropriate and that no treatment beyond adequate local excision is justified for genuinely favorable tumors.

FEW malignant neoplasms are more poorly understood by most practicing physicians than malignant melanoma. This lesion, whether arising *de novo* or appearing to develop in the site of a pre-existing, benign, long-standing nevus, has a relatively **favorable** prognosis and should be approached as such on clinical and histologic grounds.

Several years ago, Newsome[1] evaluated the opinions of practicing physicians in North Carolina regarding the prognoses for so-called clinical stage I lesions of ten common neoplasms. The responding physicians were regularly correct in the assessment of prognosis with the exceptions of malignant melanoma and laryngeal cancer. The inappropriately pessimistic prognosis commonly attributed to melanoma may be related to the fact that many cases are successfully treated as outpatients or during brief hospital admissions; most physicians are educated in the hospital environment and are therefore impressed by an apparent high proportion of ominous-appearing, locally recurrent or metastatic melanomas. In any case, surveys carried out in North America as well as Scandinavia and Australia indicate that approximately 60% of all patients with stage I* melanomas are cured by **adequate** local excision. My thesis is that the same rational diagnostic and treatment plans that are implemented for other malignant tumors are warranted for malignant melanoma as well.

Diagnosis

Determination of which lesions warrant biopsy can be simplified. Although the removal of all nevi in a population is impractical, a very workable rule of thumb is to recommend excisional biopsy for any lesion that is a source of genuine concern to a patient. The patient may have difficulty describing subtle changes in a long-standing nevus. However, the classic characteristics of melanoma are easily identified. When visible, the typical melanoma is characterized as enlarged, raised, ulcerated, erythematous or bleeds easily. Only by prompt biopsy of all such lesions can

From the Department of Surgery, University of Louisville School of Medicine, Louisville, Kentucky. Reprint requests to Doctor Polk, Department of Surgery, University of Louisville School of Medicine, Health Sciences Center, P. O. Box 35260, Louisville, Kentucky 40232.
Received at KMA 8-23-78.

Table 1

SCHEMES FOR PATHOLOGIC ASSESSMENT OF MALIGNANT MELANOMA

Author	Method	Impact on Prognosis
Breslow[5]	Thickness	< 0.76 mm very good
Clark[3]	Depth	Deeper levels (IV, V), poorer
Milton[4]	Gross configuration	Nodular worse, flat better

one honestly reassure the patient as well as establish early diagnosis if, in fact, melanoma does exist.

Those lesions occurring on sites of repeated trauma such as belt lines, strap lines, or the palms or soles are especially worthy of early excision. For virtually all such lesions, local excision and primary suture should be performed. Pathologic confirmation should be obtained before even adequate local excision is carried out. Epstein et al[2] found that incisional or excisional biopsy effects no harm whatsoever, provided that subsequent definitive excision is accomplished within a few weeks. The only serious errors made during initial contact with such patients are cauterization without obtaining a specimen for pathologic study and indefinite deferral of biopsy. Although excisional biopsy is supported theoretically by many, the superiority of that technique over incisional or punch biopsy has not been confirmed.

Classification

Attempts to classify melanomas with respect to their biologic behavior and clinical prognosis have been based on a number of pathologic characteristics of the lesion (Table 1). Significant characteristics are: depth of lesion (Clark[3]), the gross configuration of the lesion (Milton[4]), and the two dimensional volume of the lesion, a characteristic subsequently replaced, regarding significance, by thickness (Breslow[5]). In any case, the depth or vertical growth phase is the most important single determinant of prognosis.[6] Reassessment indicates that Breslow's measurement of thickness by any ocular micrometer is extremely reliable. Virtually no patient with a melanoma less than 0.76 mm in thickness died of that neoplasm.[7] Table 2 delineates a group of reliable indicators of prognosis upon which treatment can be rationally based.

Once the diagnosis of malignant melanoma is established, preoperative evaluation is a simple matter. The most common distant metastases are to liver and lungs, and simple clinical, radiographic, and laboratory evaluation of those sites is often sufficient to disclose melanoma when it exists. Metastatic involvement of the regional lymph nodes occurs in approximately one patient in five with an intact primary melanoma. Therefore, careful clinical assessment of draining nodal groups is indicated. Often the opposite nodal group will serve as an appropriate frame of reference for lymphadenopathy, which is very common in rural and industrial populations. Lymphangiography is not helpful in such evaluations. Metastases to bone are very rare.

Primary Therapy

The keystone of treatment of malignant melanoma is **adequate local excision.** What is deemed adequate obviously varies with the function of the afflicted body part. Typically, a margin of several centimeters is preferable although this is frequently and successfully violated in the case of lesions which occur on the face. While one might accept margins of as little as 1 cm on the face of a young woman, a margin of several centimeters can be obtained on the back of an older man. More objective expression of the requisite lateral margin has been proposed and is under evaluation at this time. In the case of a subungual melanoma, digital amputation is usually required to achieve adequate local excision. The depth of the initial incision is also subject to some legitimate variation. Traditionally, surgeons have preferred to excise down to and include the investing fascia of the body part. However, Olsen[8] has shown that inclusion of the investing fascia with the excision site in melanoma of the lower extremities actually promotes the likelihood of disseminated disease. Our present practice is to spare the fascia on the legs. In general, such excisions warrant coverage with split thickness skin grafts. Closure with local flaps (full thickness reconstruction) should always be avoided as a primary procedure. Such a closure often conceals recurrence, if such be the case, or permits spread of locally recurrent disease into the base of the pedicle in some patients.

The use of radiation therapy to control the primary tumor has been infrequently espoused, the general contention being that melanomas are relatively radio-resistant. Poor responses to

Figure 1. A Hutchinson's melanotic freckle, or lentigo maligna melanoma, has an irregular margin, some areas of regression and tends to invade deeper structures less regularly than other variants.

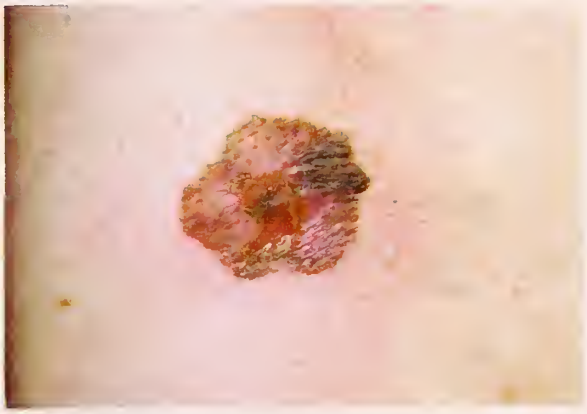

Figure 2. Superficial spreading melanoma is a misnomer that often leads to incomplete treatment of a lesion that is capable of metastasis and causing death of the host. Note the variable coloration and areas of regression.

radiotherapy have been noted in cases of visceral metastases although some cutaneous metastatic, or "in transit," melanomas have responded marginally.

Adjunctive Therapy

Adjunctive treatment has been the most controversial and least understood aspect of therapy; it refers to all treatment other than adequate local excision of the primary melanoma. The issues most widely discussed include the treatment of clinically normal regional lymph nodes, the utilization of isolated perfusion chemotherapy for extremity lesions, and the use of immunotherapy.

Should the regional lymph nodes appear to contain malignant melanoma in the absence of disseminated disease, virtually all agree that **therapeutic** dissection of the afflicted lymph node chain should be carried out. However, even though such patients represent a relatively adverse group, (i.e., a primary intact tumor and synchronous regional metastases), the salvage rate approaches 40% at five years. There is no data to suggest that *en bloc* resection (in continuity) with a primary lesion that is **remote** to the nodal area increases the overall survival rate. This has been pursued by some to ridiculous extremes (i.e., a great toe amputation connected to an ilioinguinal lymphadenectomy by a narrow strip of skin the length of the extremity). The concept appears to have lost precedence deservedly.

Elective resection of regional lymph nodes draining a primary intact melanoma when they appear to be **normal** clinically was widely practiced until the mid 1960's. The original data supporting this concept was based entirely on comparisons of survival among **clinically** noncomparable groups of patients. Furthermore, at no point did the proponents of routine elective lymphadenectomy consider the adverse effects of an operation which was **not** beneficial, at best, in nine of ten patients. After objective reassessment of the situation, we, as well as others, have found that so-called "prophylactic" regional lymph node dissection is infrequently warranted in patients with melanoma.[9-12] Indeed, the use of the various adjunctive treatments may be justified by reference to Table 2. A vigorous treatment regimen is indicated for those patients with multiple unfavorable prognostic factors; whereas, conservative management is advised for those patients with multiple favorable factors. More extensive discussion, evaluation, and documentation of this point is referenced elsewhere.[11] In summary, present national and international opinion has been inclined toward the more conservative approaches to the clinically normal lymph nodes. The patient with a favorable lesion is spared elective dissection, which is now appropriately reserved for those patients with a legitimate likelihood of regional metastases.

Regional perfusion chemotherapy was introduced more than 20 years ago by Creech, Krementz, and associates.[13] This modality isolates the affected extremity with perfusion, using the pump oxygenator to deliver very large doses of chemotherapeutic agents at high temperatures. To date, we have little but testimonial evidence as to its efficacy.[2] Just as is now the case for elective

Table 2

PROGNOSTIC FACTORS IN MALIGNANT MELANOMA

Favorable		Unfavorable
Female	>	Male
Upper extremity	> Lower extremity >	Trunk
Superficial	>	Deeply invasive
Small diameter	>	Large diameter
Flat	>	Nodular

regional node dissection, it would seem that adjunctive treatment by isolated chemotherapeutic perfusion should be confined to those patients with extremity melanomas who are otherwise good risks but who have relatively aggressive lesions as indicated in Table 2. Peculiarly, it has been well documented that the morbidity and mortality associated with isolated regional chemotherapeutic perfusion for melanoma is **less** than that associated with regional node dissection.[14] Indeed, in my personal experience, 112 perfusions have been conducted over a 13 year period without loss of limb or life. Furthermore, there are impressive examples of very high objective response rates in patients undergoing palliative perfusions for multiple regional recurrences (i.e., in-transit disease). A matched pair analysis of clinically and histologically similar lesions treated with and without perfusion is in progress. Pending that study, my present practice is to carry out isolated perfusion at 42° C in-flow with *l*-phenylalanine mustard and actinomycin D temperature for seemingly unfavorable lesions located on extremities. Doses of two to five fold which are tolerable systemically are used.

Perhaps most difficult to evaluate objectively is the present vogue of **immunotherapy.** Immunotherapy bears several pseudonyms, but is intended to enhance the patient's responsiveness against melanoma by a variety of relatively nonspecific immunostimulants. Unquestionably, **tumor-specific** antibodies are identifiable in melanoma patients and have been demonstrated differentially in numerous investigations.[12,15,17] Whether these are therapeutically significant, or simply a sign of the ebb and flow of the host-tumor battle, remains to be determined. The bulk of the data suggesting that immunotherapy is beneficial is based upon historical controls, a notoriously deceptive practice. On the other hand, Morton and colleagues[16] have, in several trials, accumulated evidence which appears to indicate that some patients with relatively unfavorable melanomas treated by adjuvant immunotherapy may experience improved survival compared to those treated by other means. Definite conclusions have as yet not been reached and it will take some time before the long-term results of these endeavors can be interpreted. The best responses attend direct injection of locally or regionally recurrent disease and visceral metastatic disease virtually **never** responds. Because melanoma is the second most common solid tumor subject to spontaneous regression and has a relatively long course in many of its patients, the evaluation of observations becomes extraordinarily difficult for all concerned.

Whereas current observations show a limited application of adjunctive systemic chemotherapy in addition to local excision (mastectomy) in selected breast cancer patients, similar data is not in hand for melanoma. At present, so-called prophylactic adjuvant systemic chemotherapy does not appear warranted for the melanoma patients whose entire disease appears to be encompassed by surgical treatment.

Follow-up

Once treatment has been completed, the patient's prognosis and follow-up scheme should be discussed in a frank and comprehensive manner with both the patient and his family. The most likely site of recurrence is in the body part involved or the regional lymph nodes. These areas should be examined at regular monthly intervals by the patient and any abnormalities reported to the physician immediately. Evidence of disseminated disease will become obvious in terms of cerebral, hepatic, or pulmonary metastases in the usual course of patient and physician follow-up. Since efforts at treatment of asymptomatic disseminated disease have been fruitless to date, a special search for occult recurrence appears unwise clinically, financially, and humanely. Our

Table 3

ADJUNCTIVE THERAPY FOR MELANOMA

"Prophylactic" dissection of regional lymph nodes
Isolated chemotherapeutic perfusion of extremities
Immunotherapy
Systemic chemotherapy

Figure 3. Malignant melanoma of the scalp must be sought with care and may present with cervical lymphadenopathy as its first sign.

Figure 4. Nodular melanoma is exactly that and bears the capacity deeply to invade and spread widely. It is the variant with the poorest prognosis.

present practice is to see patients every two months following treatment for the first year, every three months for the second year, every four months for the third, and every six months thereafter. Each examination carefully assesses the primary site, regional and remote nodal groups, and hepatic palpation. Chest roentgenograms are done annually. The physician should emphasize to the patient the likely signs of additional disease and should be prepared to see the patient promptly when signs worrisome to the patient ensue.

Treatment of Recurrence

Should recurrence develop, treatment is primarily a function of site and location. The metachronous development of regional nodal metastases in an extremity certainly warrants therapeutic regional node dissection. This modality may, in some cases, be justifiably complemented by isolated chemotherapeutic perfusion of that extremity, reasoning that there may be residual tumor cells in the extremity and this condition of minimal tumor burden is the theoretic ideal situation for chemotherapy. Multiple lesions occurring over an extremity, so-called "in transit" metastatic disease which appears between the primary site and the regional nodes, are particularly amenable to isolated chemotherapeutic perfusion, the efficacy of which is often enhanced by adding a third drug, increasing hyperthermia, and re-excising local disease as warranted. Amputation of a major extremity is rarely, if ever, warranted for melanoma, based on uniform failure to control the disease and the loss of an otherwise useful extremity. Isolated pulmonary metastases as well as metastatic tumors of other origins have been excised under very special circumstances; however, long-term survival is uncommon. Hepatic metastases do not lend themselves to such excisions of similarly low risk. Submucosal metastasis to the small bowel is relatively common and characteristically presents as acute intestinal obstruction. The acute complication is alleviated by resection of the involved segment although long-term survival of such patients is virtually unknown.

This review has minimized the role of systemic chemotherapy in the melanoma patient because definition of benefit from such endeavors has been difficult, if not impossible. The chemotherapeutic agent has changed from time to time and the end results have been quite variable. As indicated before, the chronic disease state and its relatively high frequency of spontaneous remission makes evaluation of any palliative treatment for melanoma more difficult than for many other neoplasms. The genuine value of aggressive systemic therapy has not yet been determined.

ACKNOWLEDGEMENTS

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*Classification formulated by W. H. Clark, M.D.[3]

Selected Reading

For general review, the interested reader is referred to an excellent 83 page report by Kopf AW, Bart RS, Rodriquez-Sains RD: Malignant Melanoma: A Review. *J Dermatol Surg Oncol* 3:41-125, 1977.

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Diabetic Retinopathy

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Background diabetic retinopathy and proliferative diabetic retinopathy both can result in severe impairment of visual acuity. In fact, diabetic retinopathy is an increasingly frequent cause of blindness. Diabetic patients with any degree of retinopathy should have ophthalmological consultation, for photographic documentation and fluorescein angiography are necessary in evaluating the disease. At the present time, photocoagulation or vitreous surgery are the treatments of choice in selected cases. Unfortunately, there are to date no curative procedures for diabetic retinopathy.

DIABETES mellitus was known to ancient Greek physicians, who were impressed by the large amount of urine that passed from the body and who thus named the disease "diabetes" after the Greek word for siphon. The discovery of insulin in 1921 lengthened the diabetic's lifespan, resulting in an increase in the diabetic population and in the incidence of the complications of diabetes, which are primarily vascular. One vascular complication of diabetes, diabetic retinopathy, is the nation's fastest growing cause of blindness. Ocular involvement in diabetes reflects in variable measure the vascular problems elsewhere in the body. Neuropathy, systemic hypertension, coronary and cerebral vascular involvement are frequent disease states found in diabetic patients. Severe involvement with proliferative diabetic retinopathy almost always has associated renal nodular glomerulosclerosis and most cases with Kimmelstiel-Wilson disease have diabetic retinopathy. The character and treatment of diabetic retinopathy will be discussed in this paper.

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It is estimated that there are between five and ten million diabetics in the United States and that less than half of them realize they have their disease.[1] Indeed, it is generally accepted that a subclinical, prediabetic state exists for a variable period of time before the disease becomes apparent. The development of retinopathy as a complication of diabetes is an almost predictable event in the natural life history of the diabetic patient. Forty percent of all diabetics have some form of retinal change, and over 95% of patients who have had their disease for 20 years can be expected to have retinopathy to some degree.

The physician who initially controls the ocular fate of the diabetic is usually the internist or family physician who has followed the patient for several years. In the patient with known diabetes mellitus, the diagnosis of diabetic retinopathy usually is not difficult. The major problem is the appropriate management of the ocular complications. All diabetic patients should be referred for a complete ophthalmological examination, especially when any abnormal fundus retinopathy is noted. Any retinopathy that is present can progress in an almost malignant fashion with highly unfavorable changes in as little as one or two months.

Diabetic retinopathy can be divided into two general categories: background (nonproliferative) retinopathy (BDR) and the more devastating proliferative diabetic retinopathy (PDR). The earliest clinical changes apparent in the BDR are generalized dilation and fullness of the veins. As the retinopathy progresses in severity, nodular beading of the veins, tortuosity, local constriction, varicosities, looping and sheathing develop. Microaneurysms are another early sign of BDR (Figure 1). These appear as small, round, red spots in and around the macular area which resemble small hemorrhages. Hemorrhages usually come and go, but microaneurysms tend to persist. Fluorescein angiography (which will be discussed later) is helpful in differentiating microaneurysms from small hemorrhages. Further evidence of the

progression of BDR is the development of both hard and soft exudates. The hard exudates are yellowish-white, often circinate in pattern, and are in the macular area surrounding the vascular area of leakage. The cotton-wool soft exudates represent localized ischemic microinfarcts and can be secondary to associated hypertensive disease.[2]

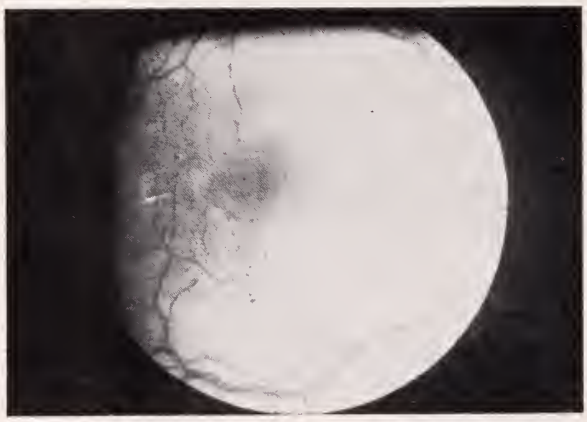

Figure 1. Microaneurysms in early background diabetic retinopathy.

Edema is the fourth manifestation of BDR. Edema occurs in the posterior retinal area and often involves the macula. It tends to be adjacent to microaneurysms and is often associated with hard exudates. Visual acuity is unfavorably influenced by the increasing degree or the longevity of macular edema. A fifth manifestation of BDR is hemorrhage. Hemorrhages in the diabetic retina, called the dot and blot type, are deep to blood vessels and tend to be located in the posterior pole. When a hemorrhage directly involves the central macula, there is associated reduction in visual acuity. Hemorrhages can also develop in front of the retina in a preretinal, subvitreous location (Figure 2). Reabsorption usually occurs, but occasionally dispersion into the vitreous follows. In addition to the above signs of BDR, in older patients the retinal arterioles become clinically affected by narrowing and by heightened light reflex. This is particularly likely in older patients with long-standing disease and systemic vascular complications of hypertension and arteriolar sclerosis.

Proliferative diabetic retinopathy (PDR) is characterized by newly formed blood vessels developing in and on the retina and optic nervehead. These vessels are principally of venous or venous-capillary origin. Neovascularization is thought to occur in response to ischemia and hypoxia in the retina and vitreous. The natural course of events is for this neovascularization to decrease when sclerosis and decreased blood flow in the retinal arterioles presumably leads to ischemia too severe to support vasoproliferation. Initially these neovascular areas are in the plane of the retina or just protruding above the surface onto the posterior vitreous face. As the vitreous detaches from the retina and moves anteriorly, these new vessels are carried forward into the vitreous cavity, often assuming enormous size and resembling ferns or fronds waving in the vitreous. These neovascular tufts are quite fragile and prone to hemorrhage with any sudden increase in central venous pressure, or minimal traumas. Hemorrhage into the vitreous is usually of sudden onset and always results in decreased visual acuity. This hemorrhage appears either as a reddish haze (imparting a murky look to the vitreous) or as a black pupillary reflex. Absorption usually takes place fairly rapidly with blood clots forming that gradually disappear. At other times, however, the vitreous hemorrhage organizes into an opaque, nonresorbing mass that requires vitreous surgery for removal. The hemorrhage evokes changes in the vitreous gel

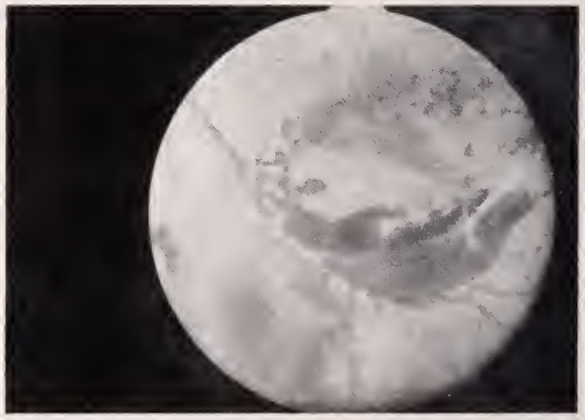

Figure 2. Preretinal hemorrhage.

which lead to fibrosis of the blood vessels and vitreous. These in turn often lead to more severe vitreous hemorrhage and traction forces on the retina. Retinal detachment often ensues, with markedly decreased visual acuity frequently resulting in functional blindness.

The foregoing signs of retinal change in diabetes can be easily seen on clinical examination. However, the ophthalmologist has several examining

Figure 3. Normal appearing fundus (left); fluorescein angiogram with microaneurysms and capillary dilitation (right).

Figure 4. Macular edema and exudates in background diabetic retinopathy.

modalities available to him to aid in appropriate management of the patient with diabetic retinopathy. Careful examination of the retina with special viewing instrumentation (biomicroscope with contact mirror and indirect ophthalmoscopy) is very important in assessing the exact character of the problem at hand. Color photographic documentation for follow-up comparative evaluation is mandatory in the modern day management of diabetic retinopathy. It is much easier and more satisfactory to follow the patient photographically than with observation alone. A special photographic technique known as fluorescein angiography is of considerable importance in evaluating patients with diabetic retinopathy. This relatively innocuous outpatient photographic study allows a dynamic evaluation of the vascular status of the retina. Examples of the pathologic changes that can be evaluated with fluorescein angiography are: incipient capillary dilitation and microaneurysmal changes often when invisible and asymptomatic (Figure 3), capillary obliterative disease, intraretinal microvascular anomalies, and neovascularization. A fluorescein study is useful both as a diagnostic and prognostic guide in diabetic retinopathy management and as an indispensable aid in the therapy of diabetic retinopathy. The fluorescein angiographic pattern determines the location and method of photocoagulative treatment to be given. B-scan ultrasound examination of the vitreous cavity and retina can be helpful in the evaluation of those diabetics with vitreous hemorrhage which blocks all view of the retina.

While a small percentage of diabetic patients experience spontaneous, if incomplete, regression, the vast majority undergo progressive worsening of their vascular involvement. Many therapeutic modalities have been tried in the management of diabetic retinopathy. It is difficult to state with certainty, but it is generally held that the well-regulated diabetic patient not only has fewer complications but also has a less frequent incidence and less severe degree of retinopathy.[3] A multitude of medications including aspirin and Vitamin C have been used as therapy for diabetic retinopathy, but the results have been inconsistent and variable. Pituitary ablation was utilized as a means of therapy in severe PDR prior to the current usage of panretinal photocoagulation. Utilizing strict criteria, pituitary ablation was successful in selected cases in decreasing the proliferative neovascular activity, but the morbidity, the surgical mortality and results were such that this procedure has been virtually abandoned in most centers.

Photocoagulation has shown the most promise and has done the greatest good in the treatment of both BDR and PDR. There are two basic types of photocoagulation delivery systems. Xenon arc photocoagulation delivers white light in a rather large, spot-sized distribution, while the more frequently used argon laser photocoagulation delivers a highly focused, monochromatic light. The principle of photocoagulation is that the absorption of focused light energy by the ocular pigmented structures, with subsequent conversation to heat energy, results in a localized thermal reaction and chorioretinal scarring. This scarring reaction can obliterate leaking areas of edema as shown in Figure 4 and bring about resorption of edema fluid and associated exudates (Figure 5). Photocoagulation can destroy those areas of capillary obliteration which, after diagnosis by fluorescein angiography, are felt to be an hypoxic stimulus to neovascularization by

Figure 5. Same case as Figure 4, showing resolution of edema and exudates after laser therapy.

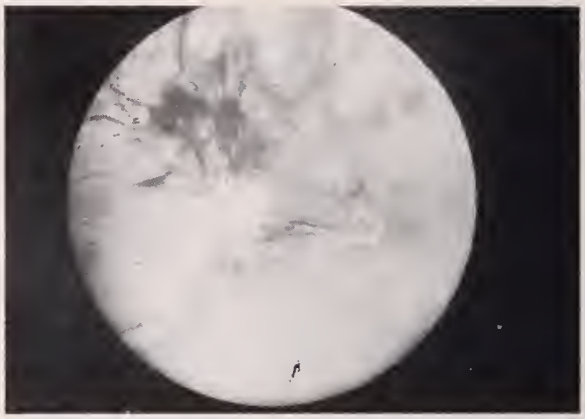

Figure 6. Proliferative diabetic retinopathy with disc neovascularization and hemorrhage.

making them anoxic and relatively inactive. In the therapy of PDR, photocoagulation can be used in a widespread treatment pattern directed to over two-thirds of the retina, a so-called panretinal photocoagulation pattern. Figure 6 shows extensive neovascular activity and hemorrhage in a 27-year-old patient. Figure 7 shows an excellent response six weeks after panretinal treatment.

Vitreous surgery, which involves intraocular surgery under microscopic control, has in recent years become the treatment of choice in selected patients. It is utilized in cases of vitreous hemorrhage that have not spontaneously cleared in a reasonable time period (six months) and in certain cases of severe PDR with associated tractional retinal detachment. These patients are usually functionally blind individuals and this surgery often results in improved visual acuity with return to gainful employment.

There are ongoing clinical studies under the guidance of the National Eye Institute concerning the nature of diabetic retinopathy and its response to medical therapy as well as to specific treatment with photocoagulation and vitreous surgery. Hopefully, these and other studies will shed an increasing amount of light on our presently inadequate understanding of this important disease process.

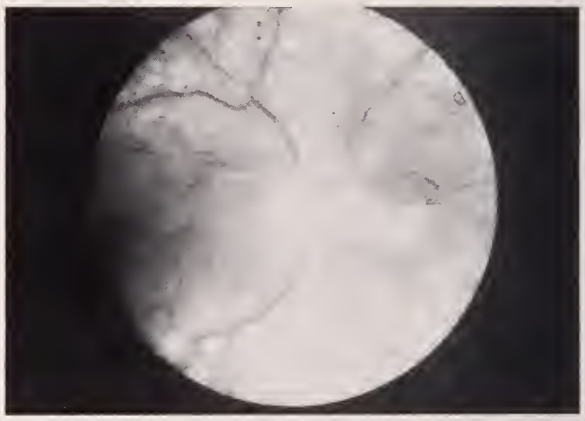

Figure 7. Same case as Figure 6, showing response to panretinal laser photocoagulation.

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GRAND ROUNDS

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This Journal feature will be presented alternately by the University of Louisville and the University of Kentucky Departments of Medicine and Departments of Surgery. We hope to have these features revolve around subjects of immediate practical interests to the practicing physician; and, for those of us not able to attend grand rounds in the teaching centers as often as we might, we hope this will represent a bit of a refresher course.

Cutaneous Manifestations of Gastrointestinal Disorders

Multiple cutaneous disorders are associated with gastrointestinal disease. Occasionally, abdominal pathology may be suspected on the basis of a characteristic cutaneous sign. In this paper, we will deal both with the classical disorders which affect both systems, and some of the newer processes and their cutaneous manifestations.

Cutaneous Disorders Associated With Gastrointestinal Polyps

Gastrointestinal polyps may occur in multiple conditions.[1,2] The four most important conditions are Gardner's syndrome, Peutz-Jeghers syndrome, neurofibromatosis (von Recklinghausen's disease), and Cowden's disease (multiple hamartoma syndrome). Each of these disorders has characteristic cutaneous markers and differentiation is very important for prognostication.

Gardner's syndrome is a disorder of autosomal dominant inheritance which usually presents with multiple cutaneous cysts, lipomas, fibromas, bony lesions, and multiple intestinal polyps.[1-3]

The extraintestinal manifestations consist mainly of skin and bony lesions. Cutaneous disease may be present very early and often leads to the appropriate diagnosis. The presence of multiple epidermal inclusion cysts, particularly if they are of unexplained etiology and if they appear at any early age, should suggest that the physician examine the GI tract. The bony lesions consist of osteomas and cortical thickening of the long bones. The osteomas seem to have a predilection for the skull. Desmoid tumors are felt to be important markers of the syndrome.[4]

Gastrointestinal manifestations are generally colonic polyps. These are adenomatous and therefore have a malignant potential which may reach 100% if left unresected.[3] In addition, patients with Gardner's syndrome seem to have a high incidence of duodenal and pancreatic carcinoma.[1,3] This feature, along with the extraintestinal findings, differentiates Gardner's syndrome from familial polyposis coli. Once a diagnosis of Gardner's syndrome is made, plans should be made for total colonic resection. In addition, follow-up must be planned for evaluation of the pancreatico-duodenal area.

Peutz-Jeghers syndrome (PJS) consists of characteristic mucocutaneous pigmentation and gastrointestinal polyposis.[1,2] PJS is also a disease of autosomal dominant inheritance. The cutaneous lesions consist of lentiginous pigmentation of the lips and buccal mucosa (Figure 1). Less frequently, the hands and feet may have similar lesions. The pigmentary changes usually appear shortly after birth and may darken later in life. Their appearance is a pathognomonic sign. The gastrointestinal lesions are characterized by hamartomatous polyps most frequently in the jejunum or ileum, but lesions may occur in any area.

The patients usually present with recurrent melena or recurrent attacks of abdominal pain due to obstruction or intussusception. There seems to be a low incidence of malignant degeneration; however, recently Utsunomiya et al have reported a strong association with colonic and

Figure 1. Hyperpigmented macules on the lips in a patient with Peutz-Jeghers syndrome

From the Division of Dermatology, University of Louisville School of Medicine, Louisville, Kentucky.

Figure 2. Multiple neurofibromas

Figure 3. Cafe-au-lait spots

gastric carcinoma.[5] The recommended treatment is still conservative, with surgical resection of obstructed areas and careful medical follow-up.

Recently, gastrointestinal lesions have been described with **neurofibromatosis.**[6,7] The cutaneous lesions consist of multiple neurofibromas (Figure 2) and cafe-au-lait spots (Figure 3). Generally, the presence of five or more cafe-au-lait spots of greater than 1.5 cm in diameter is considered diagnostic. However, axillary freckling (Crowe's sign) may also be pathognomonic (Figure 4). This disorder is an autosomal dominant with variable penetrance. Not infrequently, polypoid lesions (histologically neurofibromas) may cause recurrent bleeding, obstruction, or less commonly, perforation. The most common symptoms are pain and melena. These lesions have a low malignant potential, but if isolated may be resected.

The cutaneous manifestations of **Cowden's disease** or multiple hamartoma syndrome (MHS) consist of multiple verrucous papules (commonly on the face) (Figure 5), a palmar keratoses, and oral papillomatosis. The syndrome has been associated with multiple tumors in other organ systems including mammary, thyroid, gastrointestinal, reproductive and skeletal systems. Approximately eight of the 32 described cases have had intestinal polyposis and two of these patients developed colonic carcinoma. The recognition and reporting of more cases will eventually determine what risk of cancer exists and, thus, what appropriate preventive therapy should be arranged.

Skin Changes in Pancreatic Disease

Diseases of the pancreas may have cutaneous manifestations which, if recognized early, may aid in the diagnosis of the underlying disease. In this brief survey, we shall consider four cutaneous disorders which have recently been linked to pancreatic disease.

Patients with hemorrhagic pancreatitis may develop areas of hemorrhagic discoloration over the skin of the costovertebral angles and umbilicus, the so-called "Grey-Turner" and "Cullen" signs. These areas of echymoses result from dissection and digestion of tissue by release of pancreatic enzymes ith accumulation of hemorrhagic fluid. These findings occur most frequently in case of fulminant pancreatitis or severe abdominal trauma with injury to the pancreas.

Figure 4. Crowe's sign—axillary freckling

Thrombophlebitis migrans is a phlebitis of both superficial and deep veins of the legs and occasionally veins of the trunk, sometimes associated with carcinoma of the lung or pancreas. It consists of localized areas of tender erythema overlying circumscribed segments of veins, sometimes lasting for weeks. After disappearing it may present in other segments of veins. It may antedate clinical pancreatic findings by months.[9] Although it is known that the affected veins are not infiltrated by tumor the exact etiologic mechanism of the finding is not understood.

Nodular subcutaneous fat necrosis is a process which consists of raised tender erythematous nodules occurring predominantly on the lower extremities and occurring with either pancreatitis or pancreatic carcinoma. Leg lesions present mainly on the lateral and posterior calves (as opposed to erythema nodosum which occurs typically over the tibia), but may also involve the upper extremities, trunk and scalp. The lesions tend to occur in crops, may resolve without scarring in days to weeks, or may become fluctuant and drain a milky-white fluid in more severe cases.[10,11]

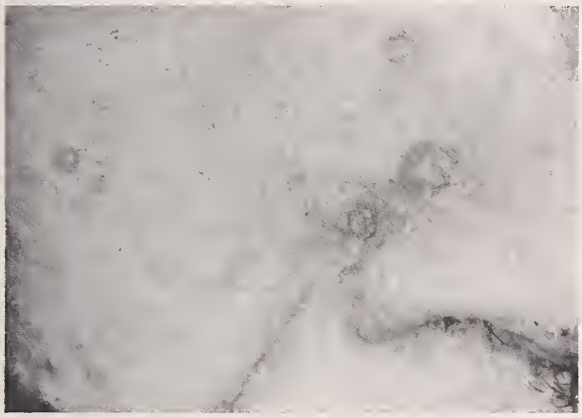

Figure 5. Verrucous papules on the face in a patient with Cowden's disease

Patients with nodules who have pancreatitis often have marked elevation of serum and urinary enzyme levels. However, occasionally the pancreatitis may be clinically silent. Patients with nodules who have carcinoma usually have an acinous adenocarcinoma, one of the lest common pancreatic malignancies, comprising 10% to 15% of all adenocarcinomas of the pancreas.[12] These patients may have an associated eosinophilia.[11]

Clinical differential diagnosis of lesions includes erythema nodosum, polyarteritis nodosa, erythema induratum, Weber-Christian disease, nodular vasculitis, drug eruption and sarcoidosis of the Darier-Roussy type. Pathological findings show "ghost cells" resulting from fat necrosis.[11]

In the last several years there has been increasing attention in the medical literature given to the **glucagonoma syndrome,** a symptom complex consisting of cutaneous findings and constitutional symptoms associated with alpha cell tumors of the pancreas.[10,13-17] When associated with this syndrome, the glucagon-secreting tumors of the pancreatic islets may be present with or without metastasis. The syndrome, which usually develops in middle age, consists of necrolytic migratory erythema (the cutaneous and mucous membrane changes), weight loss, generalized weakness, and occasionally diarrhea. Normochromic and normocytic anemia is usually present along with hyperglucagonemia, glucose intolerance, and sometimes frank diabetes mellitus.

The skin lesions of necrolytic migratory erythema consist of scaly erythematous macules and papules, often annular or arciform; flaccid bullae, and erosions with crusting which occur predominantly on the central third of the face, the lower abdomen, groin, buttocks, thighs, perineum and distal parts of the extremities. The lesions may have spontaneous exacerbations and remissions and usually do not respond to topical therapy. Excision of the tumor usually leads to clearing of lesions as well as the associated abnormalities. Hyperpigmentation may develop in lesions which have healed. Mucous membrane findings are common in the syndrome. These include stomatitis, glossitis, angular cheilitis, vulval vaginitis and dermatitis of the perianal skin. Nail plates may become thin and friable. The etiologic mechanism of the mucocutaneous changes is unknown.

The clinical differential diagnosis of necrolytic migratory erythema includes a number of entities, since the mucocutaneous findings may be so polymorphous. Included in the list are seborrheic dermatitis, chronic benign familial pemphigus (Hailey and Hailey disease), subcorneal pustular dermatosis (Sneddon-Wilkinson disease), pustular psoriasis, toxic epidermal necrolysis, chronic erythema multiforme, acrodermatitis enteropathica, and acquired zinc deficiency. Failure of rash to respond to topical treatment in the presence of the above constitutional symptoms and laboratory findings should raise one's clinical suspicion to consider the diagnostic possibility of glucagonoma. Since metastatic disease is present in only about half of cases at the time of diagnosis, an awareness of the findings of necrolytic migratory erythema may be of extreme importance to the patient's ultimate prognosis.[10]

Inflammatory Bowel Disease

Idiopathic nonspecific **ulcerative colitis (UC)** is a chronic inflammatory disease of the bowel, primarily involving colonic mucosa and submucosa. Clinically, it is characterized by recurrent bouts of bloody diarrhea, abdominal pain, rectal bleeding and fever.[18] Although the colon is the principle site of involvement, a number of associated conditions suggests that this may be a systemic disease.[19] These include rheumatoid arthritis, liver disease, and various cutaneous disorders including pyoderma gangrenosum, erythema nodosum and leukocytoclastic vasculitis.[20,21]

The cause of ulcerative colitis is unknown, but recently an autoimmune process has been proposed.[19] Antibodies to colonic mucosa have been demonstrated, but the possibility that they develop secondarily to a preexisting non-immunologic injury of the colon cannot be ruled out. The pathology is believed to begin with a vasculitis.

Pyoderma gangrenosum (PG) is the most characteristic skin lesion that develops in patients with ulcerative colitis and is seen in at least 5% of cases of ulcerative colitis.[20,22] Trauma sometimes is an initiating factor.[22,23] Initial skin lesions are papules or pustules which are followed by ulceration. The characteristic lesion is an ulcer,

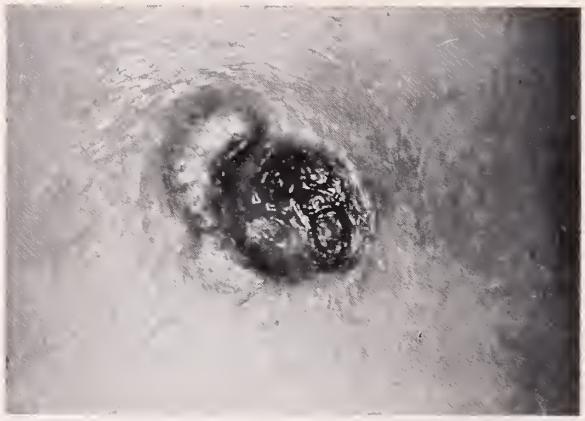

Figure 6. Pyoderma Gangrenosum—note the undermined margins

irregular in outline, with a ragged, bluish-red overhanging border, a red edematous crater, and a necrotic base (Figure 6). The etiology is not infectious but more likely PG represents an immune complex disease. Biopsy reveals a vasculitis with thrombosis, hemorrhage and necrosis with both acute and chronic inflammation.[24] The disease often correlates with active bowel disease. Treatment includes local care and systemic agents which will treat the underlying bowel disorder. In addition, sulfones, corticosteroids and antimetabolites may be necessary to control the PG.

Erythema nodosum occurs in up to 10% of cases of ulcerative colitis and consists of indurated erythematous nodules, mainly on the shins, but occasionally on the arms or trunk. Nodule development may be accompanied by fever, malaise and joint pain and arthritis. The nodules may soften and ulcerate.[24] This occurs more often in regional enteritis.

Thrombophlebitis develops in one to ten percent of patients with ulcerative colitis, but is seen in 30% to 40% of cases at autopsy.[25] Ulcerative colitis and regional enteritis, like disseminated malignancy, are associated with the hypercoagulable state with increased platelets and factor VIII activity. Arterial thromboses, both cutaneous and visceral, have been described.

Regional enteritis (Crohn's disease) is a chronic cicatrizing inflammatory disease of the gastrointestinal tract, producing segmental thickening of the bowel wall and narrowing of the lumen.[18] Histologically, the basic finding is a mononuclear granuloma of the submucosa and serosa resulting in fibrosis, inflammation, ulceration and destruction, and this is also reflected in the most common skin lesions. **Perianal and perirectal abcesses** and fistulae (Figure 7) are the most important signs of regional ileitis and are found in 15% to 50% of the cases.[26] Fistulae may be the first manifestation of the disease if the intestinal disease is mild and asymptomatic. Erythema nodosum is more common in regional enteritis than ulcerative colitis and occurs in up to 25% of cases.[20] **Pyoderma gangrenosum** occurs rarely and much less than in ulcerative colitis. Thrombophlebitis is not commonly observed in regional enteritis.

All of the skin lesions mentioned above usually respond to medical or surgical treatment of the basic disease, and also improve during periods of remission.[20] Erythema nodosum, for example, occurs as an episodic manifestation of bowel disease in many patients, with snychronous exacerbation and simultaneous resolution of both the skin lesions and the bowel disease. Some patients, however, are refractory to treatment, especially those with pyoderma gangrenosum.

Hereditary Hemorrhagic Telangiectasis (Rendu-Osler-Weber syndrome)

Rendu-Osler-Weber disease is characterized by a triad of telangiectases, hemorrhage, and familial history.[27,28] It is inherited as a simple autosomal dominant trait.[29] The earliest manifestation of the disease is nose bleeds, which starts in late childhood or at puberty.[30] The mucocutaneous lesions first appear in early adulthood and consist of cherry red macules 2-3 mm in size. Later these become more telangiectatic and are associated with angiomas of 1 cm in size. Venules may participate in the telangiectasia, giving the lesions a violaceous hue. The sites of predilection for the cutaneous lesions are the face, ears, chest, arms, tips of the fingers, (Figure 8) nose, and nail beds. Similar lesions are noted throughout the mouth, the nasal mucosa, the pharynx, and larynx, the entire gastrointestinal tract, the liver, the genital urinary system, the brain and spinal cord. Therefore, besides gastrointestinal hemorrhage, patients with Rendu-Osler-Weber syndrome may have genitourinary bleeding, cerebral vascular accidents, or pulmonary fistulas.[31,32]

Frequently, within an involved family, there is involvement of the same organ. Hemorrhage tends to be more severe in males than females. New lesions frequently increase in number during pregnancy and the nose bleeds become more severe. Patients with Rendu-Osler-Weber syndrome do not have any abnormal laboratory tests. Therapy is primarily directed at the control of hemorrhage and blood replacement when necessary. Electrocauterization of bleeding points often times is helpful. In severe cases skin grafts from the buttocks to the anterior third of the nasal septum may produce striking results. Systemic estrogenic therapy has been shown to convert the nasal columnar epithelium to squamous epithelium and has been advocated to control nose bleeds.[33] The results appear to be highly variable.

Figure 7. Perirectal fistulas in Crohn's disease

Pseudoxanthoma Elasticum[34]

Pseudoxanthoma elasticum is a generalized disorder of elastic tissue, which is determined by an autosomal recessive gene.[35,36] The skin lesions consist of small yellowish papules which may become confluent and appear like "chicken skin" (Figure 9). The lesions occur most commonly along the sides of the neck, the axilla, groin, and the bends of the arms and knees. Angoid streaks of the eyes occur in over 50% of the cases. They are due to rupture of Bruch's membrane. Also, changes occur in the small vessels of the retina and produce hemorrhage and atrophy. Since the disease is a generalized problem, elastic tissue degeneration in the media of arteries occur with secondary deposition of calcium. This leads to the development of cardiac problems, hypertension, aneurysms and ruptured blood vessels.[37] The damaged blood vessels may lead to severe hemorrhage from the stomach or intestines. The initial symptom is often times a change in vision which is brought on by a slight tap to the head. Up to his point the patient may not notice the early lesions on the sides of the neck. The overall prognosis is poor. Blindness may develop and rupture of blood vessels frequently leads to premature death.

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Figure 8. Telangiectatic lesions seen in Rendu-Osler-Weber syndrome

Figure 9. Chicken skin appearance of the neck in pseudoxanthoma elasticum

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A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should contain: 1) a brief statement of the paper's purpose, 2) the approach used, 3) the material studied, and 4) the results obtained. The synopsis should be able to stand alone and not merely duplicate the conclusions.

References should be cited consecutively in the text and should contain, in order, the author, title of article, source, volume, inclusive page numbers, year. Journal abbreviations should conform to the Index Medicus. The Journal of KMA does not assume responsibility for the accuracy of references used with scientific articles.

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SPECIAL ARTICLES

In Remembrance: William Harvey (1578-1978)

Billy F. Andrews, M.D.

It is altogether fitting and proper that the medical profession should honor the 400th anniversary of William Harvey, Britain's most brilliant physician, who reintroduced the experimental method in anatomy and physiology and described the circulation of the blood. Harvey was born in Folkestone, England on April, 1, 1578, the eldest of nine children to prosperous merchant parents. He attended the King's School at Canterbury and was educated at Gonville and Caius College, Cambridge where he received his bachelor of arts degree in 1597. Fortune allowed him to complete his medical degree in 1602 at the University of Padua, then accepted as the primary medical center of the world where Galileo's influence was being felt and the master anatomist and teacher, Fabricius de Aquapendente, became Harvey's "informant of the way."

Shortly after returning to England, he received an M.D. from Cambridge, practiced medicine in London and in 1604 married Elizabeth Brown, daughter of the royal physician to Queen Elizabeth and James I. In 1607 he was elected to the Royal College of Physician's, which was to become a major lifetime interest and recipient of his will. Soon after his appointment as physician to Saint Bartholomew's Hospital, he also became professor of anatomy and surgery and Lumleian Lecturer. Appointments, first as personal physician to James I, and then to Charles I, no doubt, afforded him support and time to complete for posterity the immortal *De Motu Cordis*, 1628, and *De Generatione Animalium*, 1651.

Today, a physician cannot observe the veins of the neck or other veins of the body or appreciate the pulse, force of contraction of the heart and quality of skin color and turgor without giving credit to William Harvey. Problems surrounding the fetal circulation, closure of the ductus arteriosus, placental circulation, amniotic fluid function as well as function and development of the gastrointestinal tract are pertinent to perinatal survival and neonatal morbidity and mortality. Although he was never able to demonstrate spermatic fertilization of the ovum, his descriptions of the human embryo from two months to term are classic for organ appearance and function. His astute observations of varying rates of growth and function of organs for specific dates of gestation in other animals clearly qualifies him as a developmentalist and first appreciator of biologic variation. His recognition of the frequency of deformed early abortuses and possibly first description of the adrenogenital syndrome in a female fetus attest to a further claim to teratology. Truly, he was a bioscientist in the purest sense of the word.

In this year, 1978, as we celebrate the 400th anniversary of William Harvey's birth, we have witnessed man on the moon, organ transplantation, artificial lungs and hearts, microsurgery, intravenous alimentation, intrauterine diagnosis and therapy and in this very year, human test tube conception. Harvey would indeed be proud of the progress of medicine, yet would still be urging us across four centuries: "that our first duty is to inquire whether the thing be or not, before asking wherefore it is"; "the facts cognizable by the senses wait upon no opinions, and that the works of nature bow to no antiquity; for indeed there is nothing either more ancient or of higher authority than nature"; and "it is in the little things that the Creator seems most great and in the inferior beings that sometimes He reveals Himself most clearly."

Doctor Andrews is Professor and Chairman, Department of Pediatrics, University of Louisville School of Medicine, Children's Hospital, Louisville, Kentucky. He was a participant in England's Harvey 400 Celebration in September, 1978.

Deceased Kentucky Physicians

1978

W. T. Anderson, Salyersville

*Kenneth R. Andrews, Lexington

Henry C. Cassini, Louisville

William J. Carey, Lexington

Thomas Clouse, Jr., Richmond

*John C. Coldiron, Manchester

Charles J. Farrell, Covington

*Francis M. Fesmire, Bowling Green

*Major S. Foster, Cynthiana

Ellis A. Fuller, Jr., Louisville

S. Hays Gailbreath, Louisville

*E. Rudolph Gernert, Louisville

Airzzie W. Greene, Jr., Louisville

*Lloyd M. Hall, Salyersville

*James D. Hancock, Louisville

Franklin Hoffman, Louisville

Zacharia K. Jones, Bowling Green

James T. Linville, Louisville

R. Claypool Neblett, Owensboro

Paul Mapother, Louisville

O. D. Maxey, Paducah

*Albert B. Morgan, Somerset

Travis B. Pugh, Jr., Bowling Green

Raymond D. Sanders, Williamsburg

Douglas E. Scott, Lexington

William S. Snyder, Lexington

Charles D. Snyder, Hazard

Robert Sory, Richmond

Frederick M. Williams, Louisville

J. Sankey Williams, Nicholasville

Jay H. Wilson, Jeffersontown

Leslie H. Winans, Ashland

List of names of deceased physicians available to The Journal as of November 15, 1978.
**Died November-December, 1977.*

EDITORIAL

CONCERN about the rising cost of medical care in the United States has continued unabated through 1978. Concern appears to be not only with the cost of individual medical services but with over-utilization of medical services. I am reminded of three recent reports attesting to this matter.

One of the articles is an editorial in a recent issue of the *Journal of the American Medical Association* addressing the large number of tonsilectomies and adenoidectomies performed annually in this country. Members of the medical profession who can best address this issue are in substantial disagreement about the indications for tonsilectomy and adenoidectomy. The matter is of concern since there are an estimated three quarters of a million tonsilectomies performed in this country annually with an estimated cost of a billion dollars.

The highly regarded Pap smear for cervical cancer has also recently come under fire. When the Pap smear was introduced some 20 or so years ago, it was recommended that women have cervical smears on an annual basis. Evidence is accumulating, according to some investigators, that such a rigid schedule is unnecessary. Those who hold this view believe that once a woman has had several annual negative Pap smears, follow-up smears need be obtained only every three to five years.

The matter of unnecessary elective surgery, periodically popularized in the press, gained recent notariety once again in a report of the moratorium on elective surgery that existed for a short time in California a few years ago. Statisticians have reportedly shown a decrease in mortality rate in this area of the country while the moratorium was in effect.

A "no response" to criticisms of this sort is no better than over-response. If there is merit to the criticism, namely, that there is unnecessary over-utilization of medical services—both diagnostic and therapeutic, then some sort of positive response seems to be in order. Again, it would appear best for the individual physician to examine his total performance.

G.R.S.

Sonnet XVII

When I consider how my light is spent
Ere half my days, in this dark world and wide,
And that one talent which is death to hide
Lodged with me useless, though my soul more bent
To serve therewith my maker, and present
My true account, lest he, returning, chide.
'Doth God exact day-labour, light denied?'
I fondly ask; but Patience, to prevent
That murmur, soon replies: 'God doth not need
Either man's work or his own gifts; who best
Bear his mild yoke, they serve him best, his state
Is kingly—thousands at his bidding speed
And post o'er land and ocean without rest:
They also serve who only stand and wait.

John Milton

O. M. S.

THREE years ago when elected president of the Jefferson County Medical Society, Dr. Robert Howell espoused the project of restoring the Old Medical School building, at First and Chestnut streets, to a state of usefulness as a home for the society and a center of community interest and education in medical affairs. The building had been designated as a landmark structure for preservation. The University of Louisville and other interested organizations had shown some concern about the restoration of the 86-year-old structure but had not actively promoted it. Ownership of the property by the Jefferson County Medical Society Foundation was acquired at a price of $110,000 with the stipulation that two years would be allowed for the development of a feasible plan for the restoration. This has been done and work on the property is now in progress.

Cost of restoration has been carefully estimated by competent architects and construction engineers at $1.5 million. It is believed that if half of this amount is provided by the society the remainder may be obtained from national and state funds which are available for restoration of old buildings, and our investigation so far tends to confirm this expectation.

A year ago, the society and the foundation launched a solicitation among the members and alumni to raise by subscription $500,000 with the expectation that if this is done an additional $250,000 may be obtained from local business firms and local foundations. To date we have been able to obtain subscriptions of a little more than $400,000 from physicians. A committee of business men headed by Dr. Fielding Rubel has been formed to solicit help from business. The prospect of obtaining the stated amount from them seems bright. We do need another $100,000 in subscriptions from physicians and believe that this will be attained by the year's end.

If restored to usefulness the building will have available for occupancy about 27,000 square feet. The society and its affiliated activities will need about 5,000 feet. Space for a community room, club and medical museum will be available on the second floor and there will be about 15,000 feet available as rental space for medically related groups, several of which have shown interest in desiring space. This should be sufficient to defray the expense of maintaining the building.

The Pope Sanitarium has been removed and this helps to provide about 60 adjacent parking spaces. The yellow brick building, of very substantial structure, is on the property we acquired. It will be left standing and will provide additional office and storage space for which there is potential demand. If and when developed, this should assure ample revenue to operate our unit.

Restoration of beautiful old landmark buildings in downtown Louisville has become a prime and essential feature in revitalizing the central part of the city. We, the Jefferson County Medical Society, have undertaken to do our part. The Old Medical School stands on the periphery of the central city area and adjacent to the now rapidly progressing Medical Center. It is an integral, and by many regarded as a very significant, part of the inner city where the action for development and beautification is now coming to a peak. When our project succeeds, we will have reason to be pleased and gratified that we, physicians, have done our fair share. We may well feel pride in such an accomplishment in our present generation.

We seek to establish, to own and operate at no financial loss, a permanent home for the society. But we seek also to provide an institution of culture and medical education to the community which will amply justify our existance among our neighbors.

There is no reason nor excuse for personal aggrandizement in such a project. The building and its beneficial functions should be dedicated to the memory of the long list of Deans of the Medical School and other distinguished teachers who have hallowed its halls in the generations past.

SAM A. OVERSTREET, M.D.

ASSOCIATIONAL NEWS

GOV. CARROLL COMMENDS KMA, CHALLENGES IT TO MORE INVOLVEMENT

As the featured speaker at the President's Luncheon, September 27, during the KMA Annual Meeting, Governor Julian M. Carroll commended KMA members for providing excellent health care for the people of Kentucky, but challenged the membership to get more involved in all aspects of community, county and state affairs.

Citing examples of health care progress in Kentucky during the past 20 years, Governor Carroll said that Kentucky's peer review legislation has become a "model study" nationally. Also, the statewide childhood screening to diagnose medical problems early will, the governor said, alleviate later illnesses which could possibly cost taxpayers. Other accomplishments listed by the governor include the construction of a new general teaching hospital at the University of Louisville, the expansion of the teaching hospital at the University of Kentucky and the establishment of neonatal care units in Louisville and Lexington.

Governor Carroll compared Kentucky's state government to individual Kentucky physicians' efforts to "work harder to provide better health care without raising fees." The result, the governor said, is that Kentucky's Cost Containment program places Kentucky 47th lowest nationally in health care costs. In like manner, he said, the state strives for government that is run in a "common-sense, business-like manner, with good personnel, effective programs and is fiscally responsible." The governor pointed out, however, that all good programs need people—people who are involved—because "people make results."

Governor Carroll closed by paraphrasing a quotation from an unknown source: "You can escape being involved in public affairs and politics, but you cannot escape the consequences of not being involved."

Gov. Julian M. Carroll (2nd from left), displays the plaque presented to him by KMA for "sincere service and dedication to the health care needs of the citizens of the Commonwealth." Shown with Gov. Carroll at the President's Luncheon during the KMA Annual Meeting are John P. Stewart, M.D. (left), Immediate Past President; Carl Cooper, Jr., M.D., President; and James B. Holloway, Jr., then-Chairman of the KMA Board of Trustees.

Digest of Proceedings Board of Trustees

September 28, 1978

Acting as temporary Chairman, KMA Secretary-Treasurer, S. Randolph Scheen, M.D., introduced the newly elected members of the Board of Trustees and the new officers:

Harold L. Bushey, M.D., Barbourville, Vice President
Walter S. Coe, M.D., Louisville, Trustee, Fifth District
Richard F. Hench, M.D., Lexington, Trustee, Tenth District
Donald C. Barton, M.D., Corbin, Trustee, Fifteenth District

The Board then elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1978-79 Associational year. Chosen as Board Chairman was William T. Watkins, M.D., Somerset. Vice Chairman is Dwight L. Blackburn, M.D., Berea. Earl P. Oliver, M.D., Scottsville, and Richard F. Hench, M.D., Lexington, were also named to the Executive Committee.

Elected to serve on the Board of Directors of the Kentucky Foundation for Medical Care were Charles B. Spalding, M.D., Bardstown; Harvey A. Page, M.D., Pikeville; Bob M. Deweese, M.D., Louisville; and Allen E. Grimes, M.D., Lexington.

Elected to the KEMPAC Board were James S. Brashear, M.D., Central City, First District; Steve Z. Smith, M.D., Louisville, Third District; Thomas A. Watson, M.D., Louisville, Fourth District; and Stephen T. Jasper, M.D., Somerset, Fifth District.

The Board reviewed the Executive Committee's recommendations for committee personnel, made appropriate changes and additions, following which committee membership for the 1978-79 Associational year was approved.

It was taken by consent that the 1979 Annual Meeting would be held in Louisville at the Ramada Inn/Bluegrass Convention Center in keeping with a previous commitment, unless extenuating circumstances require a change in site. The Board will make its final commitment in December for the location of the 1979 Annual Meeting.

Before adjourning, the Chairman set the date of the next Board of Trustees' meeting as December 13-14, 1978, at the KMA Headquarters Office in Louisville.

Members in the news

NEW MEMBERS

BOYD

Kenneth R. Hauswald, M.D., Ashland
Maurice J. Oakley, M.D., Ashland

FAYETTE

Paul S. Collins, M.D., Lexington
Kent L. Davis, M.D., Lexington
W. David Hager, M.D., Lexington
John C. Hunsaker, II, M.D., Lexington
Mary Ellen Walker, M.D., Lexington
John V. Zoek, M.D., Lexington

MADISON

William Mitchell, M.D., Richmond
James A. Ewing, M.D., Campbellsville

HONORS BESTOWED

Benny R. Bailey, Ph.D., and **Warren G. Stumbo, M.D.,** of Hindman, Kentucky were among seven Americans who were recently named winners of the Rockefeller Public Service Award for 1978. The Appalachian natives shared the $10,000 award for establishing a model health service program in Knott County, Kentucky. Doctor Bailey and Doctor Stumbo are president and medical director of East Kentucky Health Services Center, a facility serving 35,000 patients.

Honorable Tim Lee Carter, M.D., U. S. Representative from the Fifth District of Kentucky, recently received the Doctor Benjamin Rush Bicentennial Award from the American Medical Association. The award is presented to a physician for outstanding contribution to the community in citizenship and public service.

Hoyt D. Gardner, M.D., Louisville surgeon, was one of three recipients of the Louisville Jaycees' Citizen-of-the-Year Award for 1978. Doctor Gardner said that he feels it is a "tribute to the profession to have a physician chosen" for the award, and that it "enhances medicine to have physicians recognized in the community." Doctor Gardner, Mrs. Mary Helen Byck and Mr. "Biff" Roberts received the Jaycees' award plaques on November 15 in Louisville.

Trustees' Report

FOURTEENTH TRUSTEE DISTRICT

Harvey A. Page, M.D., Pikeville

In my last report to the KMA Journal the Methodist Hospital of Kentucky was without the services of a pathologist. I am happy to report at this time that we now have the services of not one but two, Doctors Kirit T. and Kusum K. Patel, who are man and wife. We have also added to our staff the services of a dermatologist, Doctor Ronald Hall; a pediatric cardiologist, Doctor Pairoj Ruktanonchai; and a radiologist, Doctor Kil B. Kim.

I would like to report that we are very pleased with the KMA Insurance Program.

The Health Departments in this area have added several new programs to their curriculum, among them being WIC, which is a food supplemental program for Women, Infants and Children. This in no way cuts down on food stamps or keeps the children out of the breakfast and lunch programs at the schools. Approximately 600 are on the program and there is room for approximately 700 in Pike County alone.

A Fluoride Mouth Rinse Program and the Kidney Detection Program have also been added, along with a hypertensive management program which lends assistance to local physicians in monitoring their hypertensive patients with diet counseling, the effects of smoking and the importance of taking their medication.

The Health Department has an automatic blood pressure recorder which enables them to screen patients in noisy environments without the use of a stethoscope. On elevated pressure for three consecutive screenings, a preliminary work up, consisting of an electrocardiogram, SMA 12 and urinalysis is done, then they are referred to their family physicians for evaluation.

Headquarters Activity

KMA had physicians and staff members in attendance at the following activities and events:

NOVEMBER

6	Ad Hoc Committee on Hospital-Based Specialists, Louisville
7-8	AMA-AHA-FAH Voluntary Effort Program, Chicago, Ill.
9	Physicians Health Committee, Louisville
9-11	National Joint Practice Conference, Dallas, Tex.
14	*Journal* Editors, Louisville
23-24	Office Closed
28	KMA-KNA Joint Practice, Louisville
30	Board of Medical Licensure, Louisville

DECEMBER

1-2	AAMSE Editors' Conference, Chicago
3-7	AMA Interim Meeting, Chicago
7	Peer Review, Louisville
12-14	FLEX Exams, Louisville
14-15	Board of Trustees, Louisville
22-25	Office Closed

JANUARY

1	Office Closed

In Memoriam

AIRZZIE W. GREENE, JR., M.D.

Louisville
1930-1978

Airzzie W. Greene, Jr., 47, died November 10 at his home in Dallas, Texas. A 1963 graduate of the University of Louisville School of Medicine, Doctor Greene practiced for several years in Middletown, Kentucky. He was a member of the American Medical Association and the Kentucky Medical Association.

DOUGLAS E. SCOTT, M.D.

Lexington
1899-1978

Douglas E. Scott, M.D., a urologist in Lexington, Kentucky, died October 28. Doctor Scott graduated in 1924 from the University of Toronto, Canada. He served on the KMA Board of Trustees and was on the Budget Committee.

J. SANKEY WILLIAMS, M.D.

Nicholasville
1908-1978

J. Sankey Williams, M.D., died October 27, 1978. Doctor Williams, a family practitioner, was a member of the Kentucky Medical Association and served as secretary of the Jessamine County Medical Society. He graduated from the University of Louisville School of Medicine in 1942.

COST CUT CORNER

Individual physicians may contribute significantly to efforts to contain health costs. This feature will present ideas for you to consider in drawing up a personal treatment plan for our health care system's economic problems. If you have an idea to share, please send it to KMA Headquarters, 3532 Ephraim McDowell Drive, Louisville, Ky. 40205.

DECEMBER—Timely claims processing can improve cash flow.

Studies show that the average physician holds an insurance form approximately 37 days prior to submitting it. Consider the benefit of improving cash flow in your office by speedy processing of claims and statements.

A clear understanding of claims procedures will expedite processing and payment and will save you and your patients time, money and frustration. Is your staff familiar with claims submission procedures of third party payors you encounter in your practice?

KMA Provides Placement Service To Physicians, Communities

Perhaps you have just completed your internship, residency, or have some other reason for needing to make a change. Perhaps you are a physician in practice and need an associate or replacement. If so, the KMA Physicians Placement Service is available to help you.

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish a practice or to relocate and to help established physicians find associates.

A semiannual listing of "Opportunities for Practice in Kentucky" is published by the Placement Service. This report lists over 100 areas in Kentucky that need family practitioners either in association with another physician or as a replacement. The Service maintains a similar listing of areas in need of medical specialists. Opportunities for partnership or group practice are also listed and requests are accepted from both physicians and communities for satisfactory placement.

As an additional service the KMA Physicians Placement Service also publishes, "Physicians Seeking Locations," a quarterly listing. This is compiled from data received from the American Medical Association, requests from recipients of the Rural Kentucky Medical Scholarship Fund, interns and residents in Kentucky, and personal inquiries to the KMA office.

It is the policy of the Placement Service to provide a two-way flow of information between interested parties, rather than try to "place" physicians in the "right" practice situation.

The Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests, and preference of type of practice. Upon return of the questionnaire, the physician is sent a list of openings in his area of interest. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities, and other specifics.

Each physician contacting this office for assistance in finding a suitable location for practice is requested to complete a questionnaire in order that his name may be carried on the next listing of "Physicians Seeking Locations."

All qualified physicians who request assistance from the Placement Service are given help. An applicant need not be a member of the Kentucky Medical Association and there is no charge either to the physician or to the community seeking the services of this program.

Inquiries may be addressed to the Physicians Placement Service, Kentucky Medical Association, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

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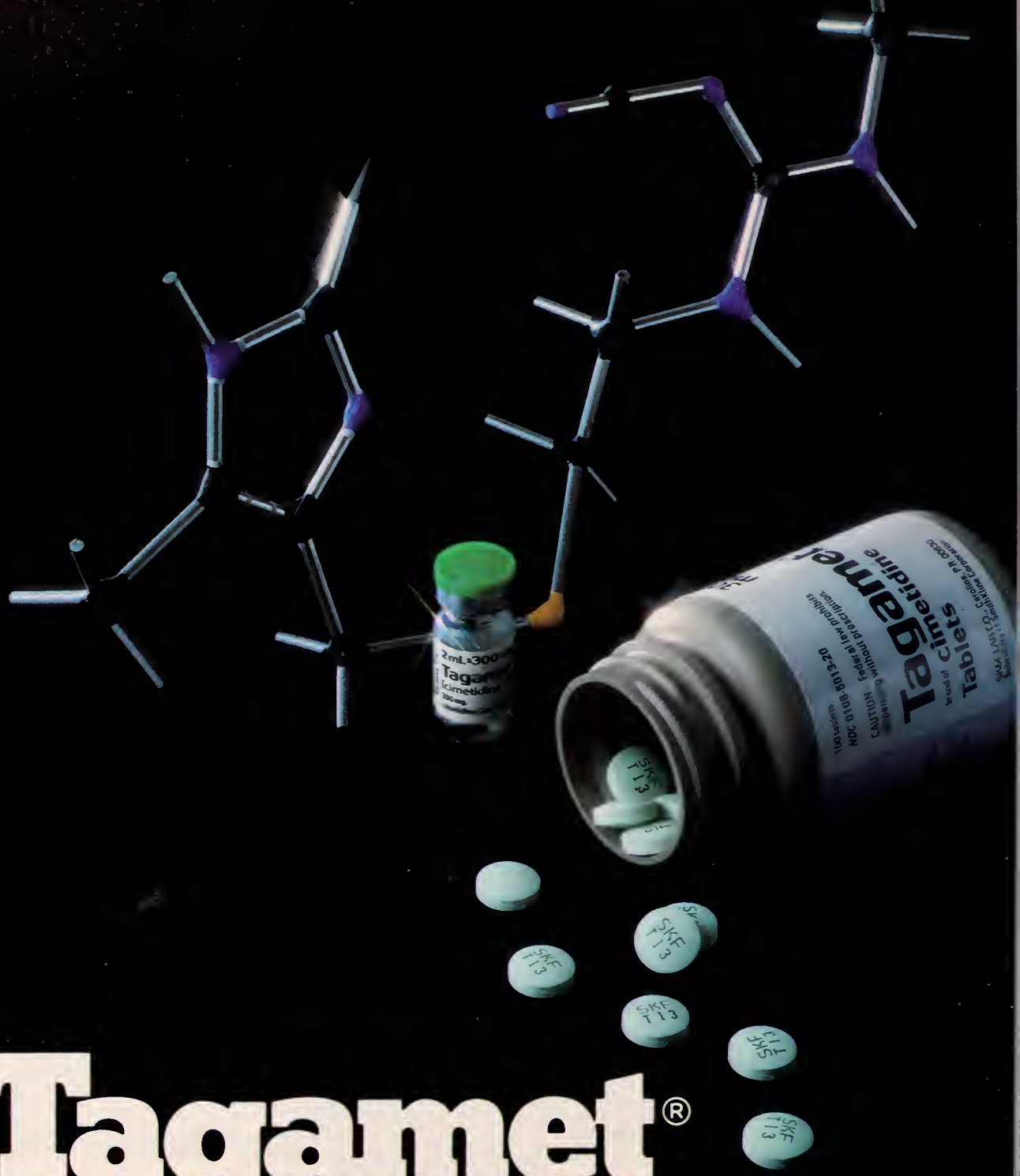

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The Joseph M. Mathews Memorial Meeting of the Kentucky Medical Association

Hyatt Regency Hotel, Lexington Convention Center, Lexington, Kentucky, September 26-28, 1978

Digest* of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Bennett L. Crowder, II, M.D., Hopkinsville

Speaker of the House, Presiding

First Session

Speaker Crowder called the 128th Meeting of the KMA House of Delegates to order at 9:10 a.m. and asked Paul J. Parks, M.D., Bowling Green, to give the invocation. He then called on Charles H. Nicholson, M.D., Lexington, Chairman of the Credentials Committee, to give the report of the Credentials Committee. Doctor Nicholson reported that a quorum was present. A motion was made, seconded, and passed that the Minutes of the 1977 session of the House of Delegates be approved as published in the December, 1977, *Journal of the Kentucky Medical Association.*

S. Randolph Scheen, M.D., Louisville, KMA Secretary-Treasurer, gave several announcements. He noted that scientific sessions would begin at 8:50 a.m. Tuesday in the Convention Center; and stressed that the highlight of the Annual Meeting, the President's Luncheon, would be held in the Convention Center on Wednesday at 11:50 a.m. Doctor Scheen reminded the Delegates that the Nominating Committee for general offices would meet at the close of the first session of the House, and Reference Committees would convene at 2:00 p.m. Monday in various rooms of the Convention Center.

He reported that the Board of Trustees, in its meeting the previous day, had voted to open the Reference Committee meetings to the press for this year only. He stated the Message Center would again be in operation throughout the Annual Meeting, and emphasized the importance of visiting the technical and scientific exhibits.

Doctor Scheen read a list of member physicians who had died since the 1977 meeting of the House of Delegates, following which the members of the House stood for a moment of silent tribute. The names of the physicians, their locations, and dates of death are as follows:

Allen, Joseph Hawley	Langley	September 23, 1977
Anderson, W. T.	Salyersville	March 1978
Andrews, Kenneth Rigdon	Lexington	October 30, 1977
Barton, Harold B.	Corbin	November 6, 1977
Cadden, Edward Robert	Louisville	November 12, 1977
Carey, William J.	Lexington	January 9, 1978
Clouse, Thomas Jr.	Richmond	January 1978
Coldiron, John Corbett	Manchester	October 1977
Davis, William Golden, Sr. D.M.D. (ASSOC.)	Louisville	April 2, 1978
Farrell, Charles Joseph	Covington	1978
Foster, Major Schuessler	Cynthiana	October 19, 1977
Fuller, Ellis A. Jr.	Louisville	February 22, 1978
Gailbreath, S. Hays	Louisville	January 4, 1978
Gernert, E. Randolph	Louisville	December 4, 1977
Hall, Lloyd M.	Salyersville	December 21, 1977
Hancock, James Duffy	Louisville	November 22, 1977
Hoffman, Franklin	Louisville	December 18, 1977
Holbrook, James A.	Lexington	November 3, 1977
Jones, Zacharia K.	Bowling Green	January 3, 1978
Linville, James T.	Louisville	July 3, 1978
Mapother, Paul	Louisville	February 20, 1978
Marcum, Max Harding	Louisville	October 19, 1977
Miner, William Richard	Ft. Mitchell	September 1977
Morgan, Albert B.	Somerset	November 16, 1977
Sanders, Raymond Dobson	Williamsburg	1978
Skaggs, Martin Hascue	Taylorsville	October 24, 1977
Sory, Robert	Richmond	May 1, 1978
Williams, Frederick Miller	Louisville	May 3, 1978
Wilson, Jay W.	Jeffersontown	March 8, 1978
Winans, Leslie Haines	Ashland	February 1978
Wright, Thomas Julian	Stanford	September 1, 1977
Zernechel, Charles	Frankfort	October 21, 1977

Doctor Crowder announced the Reference Committee appointments as follows:

Reference Committee No. 1

N. H. Talley, M.D., Princeton, Chairman
Donald R. Neel, M.D., Owensboro
Wyatt Norvell, M.D., New Castle
Carroll H. Robie, M.D., Louisville
Gene T. Watts, M.D., Hindman

Reference Committee No. 2

Allen E. Grimes, Jr., M.D., Lexington, Chairman
Keith E. Ellis, M.D., Benton
Paul J. Sides, M.D., Lancaster
Donald T. Varga, M.D., Louisville
Raymond D. Wells, M.D., Inez

**Editorial Note: A tape recording was made of the two sessions of the House of Delegates, and any member who desires to examine the transcript of these proceedings may visit the Headquarters Office and listen to the recordings.*

Reference Committee No. 3

Charles C. Smith, M.D., Louisville, Chairman
C. Bruce Caplinger, M.D., Hopkinsville
Millard C. Loy, M.D., Columbia
Edwin J. Nighbert, M.D., Lexington
O. M. Patrick, M.D., Frankfort

Reference Committee No. 4

James A. Baumgarten, M.D., Owensboro, Chairman
Glenn W. Bryant, M.D., Louisville
Don E. Cloys, M.D., Richmond
Willis P. McKee, M.D., Shelbyville
William R. Yates, M.D., Hebron

Reference Committee No. 5

Ronald D. Hamilton, M.D., Lexington, Chairman
E. Dean Canan, M.D., Louisville
James C. Embry, M.D., Paducah
John W. McClellan, M.D., Henderson
Robert E. Smith, M.D., Covington

Reference Committee No. 6

Cecil D. Martin, M.D., Carrollton, Chairman
Leslie W. Blakey, M.D., Lexington
James W. Forrester, M.D., Louisville
R. Gary Marquardt, M.D., Murray
R. D. Pitman, M.D., Williamsburg

Doctor Crowder announced that the tellers for both sessions would be Larry O. Brock, M.D., Elkton, Chairman; Phyllis J. Corbitt, M.D., Wilmore; and Paul M. Walstad, M.D., Harlan.

Doctor Crowder then called on John P. Stewart, M.D., who gave a brief Presidential Address and recognized Hoyt D. Gardner, M.D., AMA President-Elect, from the audience. Doctor Stewart thanked the House for the privilege of serving as KMA President.

The Speaker then asked the two AMSA Presidents to give their reports. Mr. Steve Henry, University of Louisville Chapter President of the American Medical Students' Association, and Mr. Steve Haist, University of Kentucky Chapter AMSA President, were both present and addressed the House.

Doctor Crowder stated he was pleased to introduce the Chairman of the AMA Board of Trustees, Robert B. Hunter, M.D., from Sedro Woolley, Washington. Doctor Hunter updated the House members on activities in which organized medicine is involved at the national level, including committee and council functions, legal action, and lobbying.

Doctor Crowder thanked Doctor Hunter for his remarks, and asked Ballard W. Cassady, M.D., Pikeville, President of the Kentucky Medical Insurance Company, to update the members on the status of their insurance company.

The Kentucky Chapter of the American Association of Medical Assistants hosted a coffee break in the lobby for the House members.

The reports of the officers and committees were presented by the Speaker and referred to a Reference Committee as follows: (Only the reports of the officers are read.)

Report of the President—Reference Committee No. 1

Report of the President, Auxiliary to KMA—Reference Committee No. 1

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker and Vice Speaker of the House—Reference Committee No. 1

Report of the Chairman, Board of Trustees—Referred to Reference Committee No. 1 with the following exception: Special Report A, Continuing Medical Education, was referred to Reference Committee No. 2

Report of the Secretary-Treasurer—Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Delegates to AMA—Reference Committee No. 1

Report of the Executive Vice President—Reference Committee No. 1

Report of the Judicial Council—Reference Committee No. 6

Report of the Rural Kentucky Medical Scholarship Fund—Reference Committee No. 6

Report of the President, Kentucky Blue Cross and Blue Shield—Reference Committee No. 4

Report of the Scientific Program Committee—Reference Committee No. 2

Report of the Scientific Exhibits Committee—Reference Committee No. 2

Report of the Continuing Medical Education Committee—Reference Committee No. 2

Report of the Cancer Committee—Reference Committee No. 2

Report of the Maternal Mortality Study Committee—Reference Committee No. 3

Report of the Committee on Maternal and Child Health—Reference Committee No. 5

Report of the Hospital Committee—Reference Committee No. 2

Report of the Advisory Committee to Blue Cross and Blue Shield—Reference Committee No. 4

Report of the Committee on Occupational Health and Environmental Quality—Reference Committee No. 3

Report of the Physician-Attorney Liaison Committee—Reference Committee No. 6

Report of the KMA-Kentucky Nurses Association Joint Practice Committee—Reference Committee No. 6

Report of the Claims and Utilization Review Committee—Reference Committee No. 4

Report of the Committee on National Legislative Activities—Reference Committee No. 3

Report of the Committee on State Legislative Activities—Reference Committee No. 3

Report of the Committee on Medicare and Other Governmental Medical Programs—Reference Committee No. 5

Report of the Technical Advisory Committee on Physician Services (Title XIX)—Reference Committee No. 5

Report of the Advisory Committee to the KMA Auxiliary—Reference Committee No. 1

Report of the Committee on Community and Rural Health—Reference Committee No. 5

Report of the Committee on School Health. Physical Education, and Medical Aspects of Sports—Reference Committee No. 5

Report of the Emergency Medical Care Committee—Reference Committee No. 2

Report of the Commission on Health Care Costs—Reference Committee No. 4

Report of the Membership and Placement Services Committee—Reference Committee No. 6

Report of the County Society Presidents' Advisory Committee—Reference Committee No. 1

Report of the Interspecialty Council—Reference Committee No. 2

Report of the Committee on Physicians' Health—Reference Committee No. 3

Report of the Committee to Study the Constitution and Bylaws—Reference Committee No. 6

Report of the McDowell House Board of Managers—Reference Committee No. 6

Report of the KMA Advisory Committee to KPRO—Reference Committee No. 4

New Business

New business was presented to the House by the Speaker and referred to the Reference Committee indicated:

(A) Resolution from KMA Board of Trustees concerning Voluntary Effort—Reference Committee No. 4

(B) Resolution from KMA Board of Trustees concerning Membership Dues Incentive for New Physicians—Reference Committee No. 6

(C) Resolution from KMA Board of Trustees concerning Legal Trust Fund—Reference Committee No. 1

(D) Resolution from Harlan County Medical Society concerning Medicare Reimbursement Areas—Reference Committee No. 5

(E) Resolution from Garrard County Medical Society concerning Federal Regulations on Minimum Obstetrical Services—Reference Committee No. 5

(F) Resolution from Garrard County Medical Society concerning Federal Regulations on Hospital Occupancy Rates—Reference Committee No. 5

(G) Resolution from Joseph G. Whelan, Jr., M.D. concerning Kentucky Senate Bill 94 (1978)—Reference Committee No. 3

(H) Resolution from Joseph G. Whelan, Jr., M.D. concerning Kentucky Administrative Regulation 902 KAR 105—Reference Committee No. 3

(I) Resolution from Letcher County Medical Society concerning Medicare Reimbursement Areas—Reference Committee No. 5

(J) Resolution from Bell County Medical Society concerning Medicare Reimbursement Areas—Reference Committee No. 5

(K) Resolution from Floyd County Medical Society concerning Certificate of Need—Reference Committee No. 3

(L) Resolution from Campbell-Kenton County Medical Society concerning Blue Cross and Blue Shield Assignments—Reference Committee No. 4

(M) Resolution from Adair County Medical Society concerning MIC Plan for Level I Hospitals—Reference Committee No. 5

(N) Resolution from Bullitt County Medical Society concerning Kentucky Administrative Rgulation 902 KAR 105—Reference Committee No. 3

(O) Resolution from Tri-County Medical Society concerning Certification of Physicians' Assistants—Reference Committee No. 3

(P) Resolution from Gradie R. Rowntree, M.D. concerning KMA Life Membership—Reference Committee No. 6

(Q) Resolution from Pulaski County Medical Society concerning Insurance Procedures and Primary Care Physicians—Reference Committee No. 4

(R) Resolution from Pennyrile Medical Society concerning Health Systems Agency West Neonatal-Perinatal Plan—Reference Committee No. 5

(S) Resolution from Jefferson County Medical Society concerning "Second Opinion" Consultations—Reference Committee No. 6

(T) Resolution from Jefferson County Medical Society concerning Local Government Ordinance Regulating the Practice of Medicine—Reference Committee No. 3

(U) Resolution from Bennett L. Crowder, II, M.D., Speaker of the House. and Peter C. Campbell. Jr.. M.D., Vice Speaker of the House. concerning a Rules Committee of the House of Delegates—Reference Committee No. 6

(V) Resolution from KMA Board of Trustees concerning Recognition of Hoyt D. Gardner. M.D.. AMA President-Elect—Reference Committee No. 1

(W) Resolution from KMA Board of Trustees concerning Kentucky Medical Insurance Company—Reference Committee No. 3

(X) Resolution from KMA Board of Trustees concerning AMA National Health Insurance Bill—Reference Committee No. 3

Vice Speaker Campbell announced the meeting places for the nominating committees for general officers and the trustee districts electing trustees and alternates. He stated the Nominating Committee would report at the close of the first scientific session on Tuesday morning, as well as at the second meeting of the House of Delegates on Wednesday evening.

The physicians on the Nominating Committee were named as follows: Thomas M. Marshall, M.D.. Louisville, Chairman; Glenn W. Bryant, M.D.. Louisville; Don E. Cloys, M.D., Richmond; Ward O. Griffen. M.D., Lexington; and L. Martin Wilson. M.D., Bowling Green. Doctor Campbell noted that Doctor Glenn Bryant would act as Chairman of the Nominating Committee as Doctor Marshall was not able to attend the Annual Meeting.

Doctor Crowder also pointed out that a synopsis of the rules of parliamentary procedure was contained in each Delegates' background material.

The meeting was adjourned at 11:45 a.m.

Second Session

Speaker Crowder called the second session of the House of Delegates to order at 6:20 p.m. on September 27, 1978, and the invocation was given by Harold L. Bushey, M.D., Barbourville. Doctor Richardson reported a quorum was present.

Doctor Holloway, as Chairman of the Board, was recognized to present the final report of the Board. He read the following Resolution which was passed by the Board at its September 27 meeting, and moved for its adoption. The motion was seconded and carried.

WHEREAS, the 1978 KMA Annual Meeting has made a substantial contribution in the field of continuing medical education and has been well received, and

WHEREAS, many individuals, organizations, and agencies, including guests, state essayists, scientific and technical exhibitors, newspapers, radio and television stations, the Hyatt Regency Hotel and the Lexington Convention Center have contributed to its success, therefore be it

RESOLVED, that this House of Delegates go on record in expressing its deepest appreciation to all individuals and organizations who have had a part in the development and implementation of the 1978 Annual Meeting.

Doctor Scheen was then called to the podium for announcements and recognition of guests from neighboring state medical associations who had attended KMA's Annual Meeting. Included were: Thomas W. Morgan, M.D., President-Elect, Ohio State Medical Association; Stephen D. Ward, M.D., President-Elect, West Virginia State Medical Association; and James A. Harshman, M.D., President-Elect, Indiana State Medical Association.

He also noted that other distinguished guests included Robert B. Hunter, M.D., Chairman of the AMA Board of Trustees; Mr. Joe D. Miller, Deputy Executive Vice President of the AMA; Rex E. Kenyon, M.D., AMPAC Board Chairman; and Kentucky's Doctor and Mrs. Hoyt D. Gardner, AMA President-Elect and Auxiliary First Vice President.

Doctor Crowder announced that the House of Delegates would transact its business according to the Sturgis Code of Parliamentary Procedure.

REFERENCE COMMITTEE NO. 1

N. H. Talley, M.D., Princeton
Chairman

Reference Committee No. 1 considered the following reports and resolutions:

1. Report of the President
2. Report of the President, Auxiliary to KMA
3. Report of the President-Elect
4. Report of the Speaker of the House
5. Report of the Chairman, Board of Trustees, with the following **exception**:

Special Report A—Continuing Medical Education Records—referred to Reference Committee No. 2

6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President

29. Report of the Advisory Committee to the KMA Auxiliary

35. Report of the County Society Presidents' Advisory Committee

Resolution C—Legal Trust Fund (KMA Board of Trustees)

Resolution V—Recognition of Hoyt D. Gardner, M.D., AMA President-Elect (KMA Board of Trustees)

Report of the President

This is my final report to you, the House of Delegates and governing body of KMA, as President. To serve in the Office of President is the highest honor one can receive from his profession, and I am filled with the deepest gratitude to you for the great privilege I have had.

With the multiple complexities in the health care field today, it is my hope we will continually remind ourselves of our primary purpose—to promote better health for the people of Kentucky and to deliver the best health care to all people, regardless of ability to pay. Let us support to the maximum the educational and research efforts of our fine University Medical Schools and all the continuing educational programs of the Academy of Family Practice, our specialty societies and the KMA. Let us seek a voice in the field of health at all governmental levels so we may influence priorities and directions in effective, not obstructive or wasteful ways. Let us combine the vast individual energies of a free society with our highly ethical sense of responsibility and dedication to achieve the best in health.

**In order to make the Digest of Proceedings of the second meeting of the House of Delegates more understandable and because it will occupy less space in The Journal, the KMA Board of Trustees passed the following motion several years ago: "that if no dissenting action on the Committee's recommendations is made either by the Committee or the KMA Board of Trustees, only the Reference Committee action on the report be printed in The Journal."*

To attempt to cover in detail all aspects of the Association and the numerous involvements would mandate unlimited words. There are many activities and committees whose functions are so well in hand that I have no comment. For instance, the fine contribution of the Judicial Council and the excellent performance of the Scientific Program Committee deserves no comment other than praise. I, therefore, would like to confine my remarks to assessments and suggestions in specific areas.

Topic I. KMA Staff

I cannot praise the overall performance of a very dedicated staff too much. Few members are sufficiently aware of their total workload and the excellence of their performance. At a future date, if financially possible, I suggest the addition of a journalist, a member of the Press Association, to promote our public relations with the media, business, labor and civic organizations.

Topic II. KMA Officers and Trustees

I have been blessed with the support and cooperation of excellent Officers and directed by an able Board of Trustees. I wish to stress to a few the obligation of a member who accepts the position of Trustee to attend all required meetings; otherwise, his local peers lack representation.

Topic III. KMA Journal

The Journal is not only our basic communicator and record, but symbolizes our primary purpose to improve health care. I hope its importance will always be recognized.

Topic IV. KMA Insurance Company

No other single effort reflects the leadership of the Association in its efforts to meet the needs of the physician. It is with pride that we launch this enterprise to solve our own problems. It is vital that all physicians support this endeavor with the purchase of stock. The Company will be successful and enable us to control our own destiny free of the dependence and encumbrances of a government-backed program.

Topic V. Public Relations

We can improve our relations greatly. Doctors talk too much to doctors. We need more exposure to other viewpoints and the problems of business and labor relative to health.

Topic VI. KMA Auxiliary

A more active role can be assigned the Auxiliary, particularly in the political field. A wealth of talent and energy is allowed to lie dormant.

Topic VII. Continuing Medical Education

I hope this will remain a voluntary effort delegated to the Aacdemy of Family Practice and the specialty societies; not mandatory and tied to licensure.

Topic VIII. Medical Licensure Board

It is vital that physicians "clean up their own act" and encourage the Licensure Board to utilize its new statutory powers to enforce the practice of ethical medicine. Every effort should be made to protect our Licensure Board's jurisdictional authority to regulate physicians and prevent encroachment by other governmental powers, such as the Health Systems Agencies. Medical staffs should control the privileges of hospital practice. Any future control over physicians' offices should be under the Medical Licensure Board and not Certificate of Need. We must protect the authority of the Medical Licensure Board to regulate the practice of medicine. All practitioners of medicine, including allied health practitioners, should meet their standards when practicing medicine.

Topic IX. Health Care Costs

The KMA Health Cost Commission is most important to keep the KMA aware of non-physician concerns and viewpoints. I am hopeful that constructive changes will come from this Commission, our only official communication with the leadership of labor and business and health insurers.

Every effort should be made to hold costs without impairing quality. Fee increases should not exceed the rate of inflation. More outpatient care, shorter hospital stays and fewer tests should be ordered. Copies of hospital bills should be given to each physician.

Physicians of Kentucky have, as a whole, performed well. Hospital per diem costs are 47th in the United States. I suspect the fees physicians in Kentucky receive are among the very lowest in the U.S. It would be interesting for the KMA Board of Trustees, in its study of health costs, to compare ranges of fees with other states to substantiate this as a fact.

Topic X. Government Programs

After 12 years Medicaid reimbursement for inpatient care was raised from 63% to 70% of the allowable fee. Every effort should be made to raise this to 100%.

Federalized peer review should remain in the hands of KPRO, not a nonphysician organization.

Every effort should be made to contain extension of regulatory power of the HSA's, as well as serve on all committees to have a voice in the policies. Recent efforts to classify hospitals as to levels of care are fraught with unlivable restrictions on ability to deliver care in the local areas. Recent efforts to issue Certificates of Need to physicians for mobile units should be challenged in court as the Kentucky Certificate of Need law excludes jurisdiction over physicians' offices.

Topic XI. Legislative Activities

The Washington Dinners should be continued. They serve well in maintaining rapport with our Congressional Delegation.

At the State level, we should always maintain close rapport with the Governor's office and the Secretary for Human Resources.

Legislation should be introduced in the Interim Committee System to repeal Certification of Radiation Operators and SB 94. The real purpose of both these laws is taxation to raise more revenue. There are already statutes and regulations to accomplish other features of these bills.

Topic XII. Other Issues

Under no circumstances should the KMA endorse restricting the right of any physician to set his own fee or to proceed with separate billing. The Radiologists and Pathologists deserve this right equal to all other physicians.

The KMA should continue to investigate the possibility of a statewide Individual Practice Association (IPA)-type HMO. This may be a vital alternative for some physicians to offer a prepaid health plan to their patients.

Topic XIII. KEMPAC

Our political ally, KEMPAC, has had great success. Our influence on government in health is commensurate with the success of KEMPAC. Broader participation is needed.

This concludes my report. I wish to thank staff, Officers and Trustees for their cooperation and help this past year.

John P. Stewart, M.D., President

Recommendations, Reference Committee No. 1

Reference Committee No. 1 reviewed the Report of the President. We wish to commend Doctor Stewart for his skill in leadership and devotion to the KMA during this past year.

The Committee recommends that this report be accepted.

(The motion was seconded and carried.)

Report of the President, Auxiliary to KMA

"Build a Bridge Through Medical Auxiliary" was the theme used during this brief year of transition. The 1977 House of Delegates voted bylaws changes resulting in a change from Fall to Spring Convention, to be held near the home city of the President, and making Fall Board in conjunction with the KMA annual convention.

A year of transition can provide an opportunity for innovation and this year proved, indeed, to give us a chance to "try on" some of our changes. Since there were no formal Fall or Spring Board meetings during this seven-month period, other opportunities were used to get together on a State level.

A well attended Leadership Conference held in Elizabethtown in August allowed county Auxiliary officers and chairmen a day of training by their state auxiliary counterparts prior to beginning their county year. Lunch and tours of the McDowell House, in Danville, during Auxiliary Day again brought us together. A revival of the Legislation Luncheon allowed auxilians from across the state to meet with each other and their legislators in Frankfort. The large attendance, in spite of the bad weather, attests to our interest in this area.

Personal contact was maintained with the county auxiliaries and members-at-large through visits and newsletters. In addition to the six counties visited as president-elect, the remaining 24 organized auxiliaries were visited individually during this time. Excellent cooperation by the counties allowed prescheduling of visits resulting in a considerable savings of travel expense and time. Members-at-large meetings were held in Bardstown, Shelbyville, and Russellville, resulting in the organization of the Nelson County Auxiliary. Five issues of the President's Newsletter were mailed to all county presidents, presidents-elect, state officers and chairmen, national headquarters, KMA advisors and members-at-large. All potential members-at-large received a complementary issue of *Bluegrass News.*

Five county presidents-elect from Campbell-Kenton, Daviess, Franklin, Hardin-Larue and Madison counties attended national confluence in Chicago with the State President and President-Elect who also attended the Southern Regional Conference in Atlanta along with the State President-Elect nominee. Six delegates, including AKMA President, and immediate Past President, represented Kentucky at the AMAA Convention in St. Louis in June.

Funds allowed for an increased budget for *Bluegrass News,* enabled the editors to publish an excellent paper. There were more articles submitted each month than could be published due to space limitations. In that this is the only communication that is directly received by each member, it is vital that we continue to support it with funds and information.

Increased emphasis on support of AMA-ERF resulted in a total state contribution of $18,453.49. Donations were presented to Doctor D. Kay Clawson, Dean of University of Kentucky Medical School for $6,059.74 and to Doctor Arthur Keeney, Dean of University of Louisville Medical School for $12,393.75.

Kentucky participated in the AMA initiated immunization awareness program entitled "Hopscotch." The materials were received late in the Fall and bad weather delayed this program somewhat; however, many of the counties have painted their hopscotch courts on playgrounds by the end of Spring.

An additional bylaws change increased substantially the duties of the regional vice presidents. They are now assisting the President and President-Elect in gathering annual reports and information for the directory. This help is so necessary with the convention in the Spring.

Diane Schmidt has continued to serve as AKMA secretary one day each week in the KMA office. She has provided such competent assistance during this year; words are inadequate to express my appreciation.

Final membership figures showed a loss of about 25 members for a combined loss over the past two years of about 85. The loss is confined to the larger county auxiliaries and members-at-large and may continue to be a reflection of the dues increase of two years ago.

Our first Spring Annual Convention—with the timely theme: The Challenge of Change . . . The Challenge of Growth—was held April 25-26 at the Barren River State Park, near Glasgow, with the Warren-Edmonson-Butler County Auxiliary as hostess. Mrs. Chester Young, AMAA President, as well as Doctor John Stewart, KMA President, were present. Judging by the interest expressed locally, moving the convention around the state will result in greater participation by the counties.

The Auxiliary has appreciated the assistance and excellent cooperation of the KMA officers, Board and Staff during this very brief year.

Mrs. Thomas E. Hall, President

Recommendations, Reference Committee No. 1

The Committee reviewed the Report of the President, Auxiliary to KMA and commends Mrs. Hall and the Auxiliary for their continuing good work on behalf of medicine in the State of Kentucky.

The Committee recommends that this report be filed.

(The motion was seconded and carried.)

Report of the President-Elect

This year has passed so rapidly and there have been so many activities that I hardly know where to begin to write a report.

Having been rather intimately involved in the affairs of the Association for the past 25 years and having had the opportunity to serve as Chairman of the Legislative Committee for the past two sessions of the State Legislature, I still feel that I may be inadequate for the upcoming year.

The KMA has been fortunate to have Doctor John Stewart as President during this year of the State Legislature and also during the formation of our KMA Insurance Company. John has had much experience in the political field in Frankfort and this has been extremely helpful for us. I expect to call upon him frequently during the coming year for guidance and advice.

I feel pride in having been able to participate in Doctor Hoyt Gardner's Campaign for President of AMA and would like to give special recognition to our Delegates, Alternate Delegates, volunteers. and staff for a job well done in St. Louis.

I am looking forward to serving you as President of KMA this coming year and I will need your support, advice, and continued friendship.

Organized medicine is being attacked on all sides and our work is cut out for us; let us all concentrate on efforts to fight off further intervention into the free practice of medicine. I promise my best.

Carl Cooper, Jr., M.D., President-Elect

Recommendations, Reference Committee No. 1

The Reference Committee next reviewed the Report of the President-Elect and offers Doctor Cooper the support of the organization and greatly appreciates his continued involvement in Kentucky medicine, his tireless efforts toward improvement and wish him well for the co ing year.

The Committee recommends this report be filed.

(The motion was seconded and carried.)

Report of the Speaker and Vice Speaker of the House

Your Speaker and Vice Speaker of the House of Delegates would like to take this opportunity to thank you for your support and cooperation during the past year.

As we go forward, your Speakers hope that a "singleness of purpose" for the Association far outweighs the honest dissention and sincere disagreement expressed by individuals or sub-groups. In the years to come, unity and solidarity will be our major strength and greatest hope.

The KMA staff has been outstanding throughout the year in providing help and assistance and their efforts have made our job easier.

We have had difficulty in appointing Reference Committees due to the late reporting by county societies of the names of their Delegates and Alternates to KMA. This report should be in by June of each year.

Your Speakers are trying to develop a format for presentation of Reference Committee Reports consistent with the format used by the AMA, and are considering the appointment of a Rules Committee to help facilitate the flow of business. These matters will be brought to the attention of the Delegates at the first session of the House of Delegates for their consideration.

We thank you for the opportunity to serve.

Bennett L. Crowder, II, M.D., Speaker
Peter C. Campbell, Jr., M.D., Vice Speaker

Recommendations, Reference Committee No. 1

The Committee next considered Report #4 of the Speaker and Vice Speaker of the House. The Committee would like to commend Doctors Crowder and Campbell for their report and recommended changes to expedite business before the House of Delegates.

The Committee recommends that this report be filed.

(The motion was seconded and carried.)

Report of the Chairman, Board of Trustees

Introduction

It has been a singular year in the face of defeat of previous years through legislative activities, particularly medical liability legislation. This past year the Board of Trustees has undertaken the responsibility of forming Kentucky's own medical liability insurance company with the cooperation and assistance of Physicians' Insurance Company of Ohio. At the present time, as you know, we have an agency which will be transferred to our independent company when we have accumulated enough stock to meet the capital requirements. I think time will prove this to be one of the most far-reaching and astute moves that the Kentucky Medical Association has ever made. You should all be proud of the time and effort that the Board of Trustees has put into this enterprise.

The second most important accomplishment of the year was the work put in by the Board of Trustees through the Legislative and Quick Action Committees during the legislative session. This activity led to peer review and confidentiality legislation as well as changes in the Medical Practice Act which were sponsored by the Association.

The Board of Trustees has begun to come to grips with the problem of cost control on a voluntary basis, thus retaining this control within our own professional group.

I should say that this has been a perfectly delightful year to serve as Chairman of the Board as we have had cooperation from all members and there has been a high attendance rate at each of the Board meetings.

The details of each of the meetings of the Board of Trustees and the Executive Committee are enumerated in considerable detail in the following report.

Summary of Board Meeting

First Meeting, September 29, 1977

James B. Holloway, Jr., M.D., Lexington, and Harold L. Bushey, M.D., Barbourville, were chosen by the Board of Trustees to serve a second term as Chairman and Vice-Chairman, respectively. A former KMA Vice-President and Fayette County Medical Society President, Doctor Holloway represents the Tenth Trustee District. Doctor Bushey, Trustee from the Fifteenth District since 1972, currently serves as Chairman of the Ad Hoc Committee on HSA's.

Newly-elected members of the Board of Trustees are:
Wally O. Montgomery, M.D., Paducah, First District
Harvey A. Page, M.D., Pikeville, Fourteenth District

Re-elected to three-year terms were: Frank R. Pitzer, M.D., Hopkinsville, Third District; Charles B. Spalding, M.D., Bardstown, Fourth District; and William T. Watkins, M.D., Somerset, Twelfth District.

Alternate Trustees elected to the Board were: James E. Adams, M.D., Paducah, First District; Henry R. Bell, M.D., Elkton, Third District; Terrell D. Mays, M.D., Elizabethtown, Fourth District; Don E. Cloys, M.D., Richmond, Eleventh District; Danny M. Clark, M.D., Somerset, Twelfth District; and Jerry D. Fraim, M.D., Paintsville, Fourteenth District.

Second Meeting, December 14-15, 1977

The KMA Board of Trustees held its second meeting of the Associational year on Wednesday, December 14, and Thursday, December 15.

The Headquarters Office Report was made by the Executive Vice President, who noted substantial increases in membership and finances.

In his report on the recent AMA Interim Meeting in Chicago, Doctor David Stevens announced that the AMA House of Delegates approved direct specialty representation whereby approved specialty societies would be able to elect their own delegates to AMA. He stressed that the primary goal of the KMA delegation in 1978 was the election of Hoyt Gardner, M.D., as President-Elect of AMA.

Neville Caudill, M.D., President of the Kentucky Peer Review Organization, reported that KPRO expected to be implementing review in all hospitals certified by Medicare and Medicaid by the end of February, 1978.

A Kentucky Pharmaceutical Association resolution dealing with the use of a rubber stamp on prescriptions to identify a physician, his DEA or license number, was endorsed by the Board.

The major item of discussion concerned liability insurance. The Board reviewed the House mandate calling for establishment of a KMA insurance company, the studies made of other states on this issue, the recent liability insurance survey conducted by KMA, and the discussions held with the Physicians' Insurance Company of Ohio (PICO). After lengthy discussion (a tape of which is on file at the Headquarters Office), the Board voted to establish a Kentucky insurance agency in affiliation with PICO to offer primary and excess coverage on an occurrence basis and to oppose any legislation to form a Patients' Compensation Fund.

A number of KMA committees reported at the Board meeting:

The State Legislative Activities Committee has formed a position on all medically-related bills that were prefiled in the Legislature. The Board gave authorization to the Quick Action Committee to make necessary decisions on any impending state and national legislative matters. In related action, the Board approved a request of the National Legislative Activities Committee to hold the Washington Dinner in 1978.

Using information reported by the Cancer Committee, the Board endorsed the concept of a statewide tumor registry and recommended it be operated and located at the University of Kentucky. The Council on Health Care Costs issued a report of its activities since its formation.

Due to a similar seminar being held by the University of Kentucky, the Committee on School Health, Physical Education and Medical Aspects of Sports has decided not to hold its annual sports seminar in 1978. In other action, the Board urged this Committee to survey state high schools on team physician use.

The Ad Hoc Committee on Primary Care submitted guidelines for the Board's information for primary care physician extenders and the Committee on Community and Rural Health announced plans to co-sponsor with the University of Louisville a seminar on "The Medical Management and Special Problems in Treatment of Alcoholism," on May 24-25, 1978.

Mr. Avil McKinney, Executive Vice President of Kentucky Blue Cross and Blue Shield, gave a thorough presentation on premium rates for the KMA Program for physicians and their employees. He also commented extensively on the rate review legislation to be presented to the 1978 Legislature.

Secretary for Human Resources, Peter D. Conn, met with the Board and held a lengthy discussion on several informational items: (1) He plans to extend the radiation operators' certification deadline for six months. (2) He supports KMA's feelings concerning physicians serving on local boards of health. (3) He announced his intention to seek legislation to create an office of the Surgeon General and outlined the role of this position which would be filled by a physician. (4) He asked for KMA assistance in revising the Health Planning Law.

Third Meeting, March 9, 1978

The third meeting of the Board of Trustees was held on March 9 primarily to finalize KMA's plans in the Professional Liability Insurance field. A legislative report was first given by the State Legislative Chairman, Carl Cooper, M.D.

It was reported that this meeting had originally been called to finalize negotiations with the Physicians' Insurance Company of Ohio in regard to a joint venture but two additional requests had been received.

Officials from Aetna, having appeared before the Executive Committee, then reported at some length to the full Board their desire to see KMA endorse Aetna and, in turn, establish a loss claim and educational program and offer additional pricing and umbrella policies.

A Medical Protective representative also appeared to report they would begin writing $1,000,000 coverage on May 1.

A Vice President of PICO then outlined in detail their plans to jointly pursue with KMA the formation of a professional liability insurance company owned by Kentucky physicians.

Following individual presentations of the three companies, questions and answers, a motion was passed that KMA accept the proposal of PICO with the intent of forming its own insurance company.

Names were then approved for service on the KMA Insurance Agency Board and plans were made for the Agency Board to have its organizational meeting on April 6. Additionally, the Board (1) endorsed the Department for Human Resources as the central agency, working in cooperation with both universities, for a statewide tumor agency; (2) directed additional correspondence be conducted with the Attorney General concerning Project Integrity (Medicaid Program); and (3) endorsed the exemption of private physician CT Mobile Scanning Units from Certificate of Need authority.

Fourth Meeting, April 6, 1978

The KMA Board of Trustees met on April 6, 1978 at the Headquarters Office in Louisville.

The Headquarters Office Report included remarks by Robert G. Cox, Executive Vice President of KMA, who outlined KMA's current activities, plans and staff changes in assignments. The Board reviewed and approved the 1978-79 budget.

The Medical Licensure board reported on its present efforts to draft regulations to certify paramedics. Paramedic certification was made the responsibility of the department as the result of action taken by the 1978 Kentucky General Assembly.

Carl Cooper, Jr., M.D., President-Elect and Chairman of the Committee on State Legislative Activities, reviewed activities of the Legislative Committee during the 1978 Kentucky General Assembly. Doctor Cooper reported that the KMA legislative program was successful.

Carl L. Wedekind, Jr. reviewed the status of the Board's decision to intervene in the lawsuit regarding the Patients' Compensation Fund. He emphasized KMA's position that the money in the Fund should be returned as soon as possible, with accumulated interest, to those who contributed to the Fund. Mr. Wedekind noted KMA's objection to any money being drawn from the Fund to pay court costs or attorneys' fees.

Other Board actions:

- Sent nominations to the Governor of physicians to serve on governmental advisory councils.
- Recognized William P. McElwain, M.D. for his service as Commissioner for Health Services.
- Presented AMA-ERF checks from the Auxiliary to representatives of the two medical schools in Kentucky.

It was reported that the KMA Insurance Agency Board would meet immediately following the KMA Board of Trustees adjournment.

Fifth Meeting, June 1, 1978

The KMA Board of Trustees met on June 1, 1978, preceding a called meeting of the KMA Insurance Agency, Inc. Board of Directors.

Doctor Stewart reported in detail on KMA activities to include that he had addressed eleven of fifteen KMA Districts recently where much discussion was held on the Kentucky Medical Insurance Company.

He indicated his desire for KMA to begin preparing for the 1980 Kentucky General Assembly. It was reported that KMA is actively participating in the Voluntary Effort Cost Containment in Kentucky and the sharing of the expenses for this activity was authorized.

Reports were submitted by the Membership and Placement Services Committee and the Advisory Committee to Blue Cross and Blue Shield. Authorization was given for co-sponsorship of the 1979 Medical Aspects of Sports Seminar with the University of Kentucky CME Department. The KMA Continuing Medical Education Committee received permission to bring representatives from the Utah Medical Education Foundation to Kentucky to discuss CME Programs.

A lengthy session was held with the president of the Kentucky Chapter, American College of Radiology, who discussed with the Board: 1) some current radiology regulations; 2) S. B. 94 relating to the inspection of X-ray equipment; and 3) the matter of separate billing by hospital-based physicians.

Other actions of the Board include:

- Endorsed a seminar on the treatment of rape victims to be held statewide.
- Endorsed a study to determine the appropriate role of barbiturates and other sedative-hypnotics in current medical practice.
- Received a report on the status of the Patients' Compensation Fund.
- Turned down an offer from HEW for KMA to be a listholder on HEW's Second Consultation on Elective Surgery Plan.
- Received a full report on recent activities concerning the formation of the Kentucky Medical Insurance Company, following which a Search Committee was appointed to seek a president of the company. An Underwriting Committee was also appointed.
- Approved purchase of stock up to $20,000 in the KMA Insurance Agency and authorized the purchase of at least $10,000 and not more than $50,000 of Class B Common Stock in the Kentucky Medical Insurance Company.

It was noted that the next meeting of the Board was its regularly scheduled session on August 9-10, 1978.

Sixth Meeting, August 9-10, 1978

A major purpose of the August Board meeting is to review the committee reports prior to their submission to the House of Delegates and to record the actions of the Board on each report for consideration by members of the House. Committee Chairmen and Trustees assigned to study the reports discussed each in detail.

Additional reports were heard by the Board from the President, the Secretary-Treasurer, the Senior Delegate to the AMA, the President of KPRO, and a representative of the Board of Medical Licensure.

A lengthy discussion was held following multiple presentations on the pros and cons of Individual Practice Associations. It was taken by consent that no action was indicated at the present time from KMA concerning involvement in a statewide Individual Practice Association.

There was also a lengthy report presented by legal counsel on the numerous legal matters now affecting medicine generally, and KMA specifically, to include a number of lawsuits in which KMA has voluntarily or involuntarily participated.

Nominees were finalized for presentation to the Governor for appointment to the Comprehensive Health Planning Council; a request to form the Big Sandy Multi-County Medical Society was approved; and numerous comments were made concerning the successful election of Hoyt D. Gardner, M.D. as President-Elect of the American Medical Association.

Another major agenda item was a complete update on progress that has been made with the Kentucky Medical Insurance Company which came into existence on July 31, 1978. Recognizing a need by the Company for financial assistance until it has become capitalized and is generating its own income, the Board of Trustees authorized up to $100,000 to be used as loans to the Insurance Company on an as-needed basis in its formative stages.

Commissioner for Health Services, Mr. Robert Slaton, was present to discuss a number of Department for Human Resources health matters to include Radiology

Regulations, Regional Boards of Health, and other matters of current interest. A lengthy question and answer session was afforded to the Board members.

A full report was given on the forthcoming KMA Annual Meeting to be held in Lexington, and the Board approved Resolutions for presentation to the House of Delegates on subjects of the Legal Trust Fund, Voluntary Effort, and reduced dues for first-year members. After receiving some separate committee reports and selecting a Judicial Council nominee for presentation to the House of Delegates, the Chairman announced that the remaining meetings of the Board of Trustees for this Associational year would be held on September 24 and 27 during the Convention.

Executive Committee

Your Executive Committee is composed of eight trustees and Officers and generally meets between sessions of the Board to facilitate the day-to-day operations of the Headquarters Office. As this report is being written, the Executive Committee has already met eight times during the Associational year; i.e., October 20 and November 10 in 1977, and February 28, March 8, April 5, June 1, August 9, and September 7, 1978. The Executive Committee has the Annual Meeting as one of its responsibilities, both in planning for one year's session and then following through in implementing the actions of the House of Delegates.

The formation of the KMA Insurance Agency, Inc. and Kentucky Medical Insurance Company were obviously two more matters of major concern. However, the Executive Committee continuously acts on a wide variety of subjects, meeting three to four hours per session, and particularly maintains close contact with the committee organizational structure.

Quick Action Committee

The Quick Action Committee consists of your President, President-Elect, Board Chairman, and Secretary-Treasurer. Without counting them, I would expect we had in excess of one dozen meetings this year. We met weekly in Frankfort during the Kentucky General Assembly in an attempt to keep up with legislative activity and map KMA strategy for the coming week.

Ad Hoc Committees

This year's Ad Hoc Committees of the Board have done a superb job. They are the Ad Hoc Committees on: 1) Professional Liability Insurance; 2) Primary Care; 3) Health Service Areas; 4) CT Scanners; 5) Mobile Diagnostic Health Services; and 6) Hospital-Based Specialists.

It is important to note some of the primary points of the Ad Hoc Committee on Hospital-Based Physicians; which are: the right of physicians to choose their method and rate of billing; that fees should not be raised just because billing methods are changed, but that reasonable administrative costs should be recognized.

Copies of the reports of all Ad Hoc Committees to the Board will be available in Reference Committee No. 1 for information.

As I complete my second and final year as Board Chairman and my last year to serve on the Board of Trustees, I wish to thank each of you for permitting me this privilege and for demonstrating your support.

James B. Holloway, Jr., M.D., Chairman, Board of Trustees

Recommendations, Reference Committee No. 1

The Reference Committee reviewed the Report of the Chairman, Board of Trustees, with the exception of Special Report A, and would like to express appreciation to Doctor Holloway as Chairman, and for his many hours of service and capable leadership to the KMA.

The Committee recommends that the report be adopted.

(The motion was seconded and carried.)

Report of the Secretary-Treasurer

As this Associational year draws to a close I think we can reflect over a hectic but productive 12 months that has seen some losses and many gains. From the beginning of the calendar year with the state legislative session up to the formation of our captive professional liability insurance company, KMA's efforts to represent the profession have been carried on efficiently and in a business like manner.

In past reports to this House of Delegates, I have listed the number of miles traveled and meetings attended by officers, members and staff on behalf of KMA. While these figures are available they do not begin to present a true picture of all the activities that have taken place. Many "informal" meetings with legislators, key government officials, important allied and external groups, and individuals have not reported yet are very important to the affairs of KMA.

Likewise, miles traveled or hours spent do not indicate all the effort put into KMA concerns. For example, our Annual Scientific meeting, which lasts only three days, takes a year to prepare for.

It is gratifying to be able to report to you that although the crush of tasks KMA is required to perform for its members has continually increased, our financial position is sound. Thanks to constant alertness for cost cutting measures and careful attention to expenditures and savings our reserves are sufficient and our dues rate is secure for at least another couple of years.

A development that will have far reaching effects was the realization this year of our own liability insurance company in August. All necessary statutory and legal requirements were met, the company was incorporated, and an incorporating board was formed. After many weighty decisions and policy commitments, the Kentucky Medical Insurance Company is now a reality and the on-going availability of competitively priced insurance is assured.

Further assurance must be in the form of membership support, through purchase in insurance and stock. Initial interest in KMA sponsored coverage has been high. Hopefully equal interest in stock purchase will be shown when the stock becomes available in the next few weeks.

For the company to be a long term reality, your support is vital. The company is physician-owned and controlled and will be run as physicians dictate. Staff representatives of the company will be available during our

meeting and I urge you to talk with them and affirm your interest.

Again this year I would like to extend an invitation to everyone to visit our headquarters office if you have not had an opportunity to do so. We have an attractive building and well maintained grounds. Our Executive Vice President has developed an efficient, courteous staff that quite capably carries out the work of our Association, and I think you will find a visit to the building interesting.

It has been my privilege to continue serving you. I have tried to carry out my duties in the best manner possible and feel confident in saying that KMA is in a strong position financially, organizationally and has admirably and ably represented and defended the profession this year.

My thanks to the officers, Trustees, and individual members who have contributed so unselfishly to our united efforts and who have made my job easier.

S. Randolph Scheen, Jr., M.D., Secretary-Treasurer

Recommendations, Reference Committee No. 1

The Committee next reviewed the Report of the Secretary-Treasurer. The Committee would like to commend Doctor Scheen for his many years of excellent work and interest in his capacity as Secretary-Treasurer.

The Committee recommends that this report be filed.

(The motion was seconded and carried.)

Report of the Editor

As the 76th year of publication of *The Journal* draws to an end, I wish to take this opportunity to briefly recall some of the accomplishments and goals of your Editorial Board.

After my appointment as Editor last September, I was privileged to represent our Editorial Board at the State Medical Journal Advertising Bureau (SMJAB) Annual Conference in New Orleans. The two-day event consisted of workshops, lectures, and a critique of our journal. Much of the information presented is now being incorporated into the editorial format of *The Journal*.

I am pleased to announce that SMJAB has selected Louisville as the site of its 1978 Annual Conference, September 22-23, at the Galt House. The SMJAB, which represents 33 state and numerous large county medical societies, will hold a two-day meeting for an anticipated registration of 150.

As previously mentioned, changes are being made in *The Journal*. Over the next year the membership will notice subtle changes in the cover and layout, along with the introduction of new scientific and organizational stories. Any change reflects the strong commitment of your Editorial Board to provide the best scientific and clinical articles, and to give the membership concise, but detailed, information on all Association activities. We believe *The Journal* is an important link of communication in the chain of the organization.

The Board of Editors, which meets monthly at 7:30 a.m., considers many clinical and scientific articles for publication, as well as examining new approaches to improving *The Journal*. The Editors invite the membership to submit original, unpublished scientific papers to be considered for publication.

The Universities of Louisville and Kentucky are to be congratulated for their excellent contributions to the Grand Rounds section. This feature continues to provide an effective opportunity for physicians in private practice to stay abreast of new techniques and technology.

Other sections, including the Cancer Page, Maternal Mortality Study Reports, and a new section to appear soon, the CME Page, require hours of preparation, and the Board of Editors deeply appreciates the committees responsible for them.

The Board of Editors regrets the departure of Mrs. Diane Maxey, Assistant Managing Editor for more than eight years. Mrs. Maxey, who is undertaking a new career, was extremely capable and her services will be missed. We wish her success in her future endeavors.

We welcome Mrs. Shirley Cook, Assistant Managing Editor, who brings to *The Journal* a varied background of journalism and business experience.

I would like to thank the members of the Editorial Board for their time, effort and devotion. Their desire to provide the membership with the best possible publication is evident as one reads *The Journal*.

Scientific Editor, Paul C. Grider, Jr., M.D., and the Board of Consultants are to be commended for their fine work in maintaining *The Journal's* high quality of scientific material.

The Editorial Board welcomes any ideas to keep *The Journal of the Kentucky Medical Association* a vital medium of communication for Kentucky physicians.

A. Evan Overstreet, M.D., Editor

Recommendations, Reference Committee No. 1

The Reference Committee reviewed the Report of the Editor and we commend Doctor Overstreet for a fine job in his first year as Editor. We are looking forward to his innovations in this capacity.

The Committee recommends this report be filed.

(The motion was seconded and carried.)

Report of the Delegates to AMA

Hoyt D. Gardner, M.D., elected as President-Elect of the American Medical Association. At its meeting in St. Louis, Missouri on June 18, the AMA House of Delegates elected the Past KMA President and AMA Trustee, Hoyt D. Gardner, M.D., to its highest post. In a spirited, enthusiastic and hard fought campaign, Doctor Gardner won over Jere W. Annis, M.D., AMA Trustee and internist from Lakeland, Florida.

This activity highlighted a busy year for the Delegates. They are: David B. Stevens, M.D., Lexington; Fred C. Rainey, M.D., Elizabethtown; and Harold B. Haller, M.D., Louisville. Alternate Delegates are: Lee C. Hess, M.D., Florence; Wally O. Montgomery, M.D., Paducah; and Kenneth P. Crawford, M.D., Louisville. These men represented the Kentucky Medical Association at both AMA House of Delegates meetings. The delegation to St. Louis included KMA President and Mrs. John P. Stewart, Frankfort; KMA Board Chairman and Mrs. James B. Holloway, Jr., Lexington; President-Elect Carl Cooper, Jr., M.D., Bedford; Auxiliary President Mrs. Charles H. Nicholson, Lexington; Trustees Cecil L. Grumbles, M.D., Louisville; and Harold L. Bushey, M.D., Barbourville; KMA House of Delegates Speaker

Ben Crowder, M.D., Hopkinsville; and Vice President, Robert S. Howell, M.D., Louisville; Fayette County Medical Society President Allen E. Grimes, M.D., and Executive Director Carolyn Larson; and Jefferson County Officers, Past President Robert DeWeese, M.D.; President Sam Weakley, M.D.; President-Elect Will Ward, M.D.; and Executive Director Harry Lehman were among others to participate in the St. Louis victory. The Blue Cross-Blue Shield organization was represented by President Don Giffen; Executive Vice President Avil L. McKinney; and Alan Leichhardt, Jim Sparrow and Jim Bingham. Many others from Kentucky attended, contributed and/or worked in the campaign. The Delegates and Alternates could not have done it alone; to all, our thanks.

Past President of Kentucky Blue Cross-Blue Shield, J. Ed McConnell, was presented on June 18 the AMA's Citation of a Layman for Distinguished Service.

Tom E. Nesbitt, M.D., a urologist from Nashville, Tennessee, was inaugurated as President. He challenged American physicians to participate in the Voluntary Effort cost containment program. In responding to the challenge of AMA critics, he stated that the AMA would survive because it continues "to provide pragmatic policies, programs and proposals to deal with contemporary health care problems," and "because it is a protector and promoter of American medicine, superb healing quality, and medical education and practice."

The House of Delegates met in two sessions during the associational year; December 4-7, 1977, in Chicago, Illinois, and June 18-22, 1978, in St. Louis, Missouri. In the future, the House of Delegates will continue to meet two times each year, generally in Chicago or other locations in the country. All future scientific programs will be conducted at different times and places.

The June, 1978 meeting contained 300 separate business items, in addition to the elections and various ceremonial functions. Major areas of activities included:

1) Direct Specialty Representation in the AMA House—Now major national medical societies directly select delegates, rather than through the Section Councils, as in the past.
2) Cost of Medical Care—The House considered the various recommendations of the AMA sponsored National Commission on the Cost of Medical Care. Some about education relative to cost consciousness were adopted. Others relative to more regulations by government were rejected. And many, such as physicians supplying manpower, were relegated to other committees for study or further action.
3) The revisions to the Principles of Medical Ethics were referred to a special ad hoc committee of the House for report at the December, 1978 meeting.
4) Membership—Dues for new members were cut by 50%. However, AMA membership remains static. This fact and its related root causes represent the most serious internal problem that the AMA now faces.

The Delegates and Alternates thank you for your confidence in selecting us as your representatives. Your comments, ideas and criticisms are welcome. We would like to hear from you.

My observation of the various societies represented in the AMA confirms my belief that the KMA enjoys the best staff in the U.S.A. My personal thanks to Bob Cox, Bill Applegate, Bob Klinglesmith, Joe Witherington and Bill Schmidt for their good efforts.

David B. Stevens, M.D., Senior Delegate

Recommendations, Reference Committee No. 1

The Reference Committee reviewed the Report of the Delegates to the AMA. We would like to thank Doctor Stevens for his very informative report and in particular to all the Delegates who were most effective in Doctor Gardner's recent election as President-Elect of AMA.

The Committee recommends this report be filed.

(The motion was seconded and carried.)

Report of the Executive Vice President

The House of Delegates has before it a heavy agenda, both in length and in subject material. For that reason, I will try to make this written report brief. However, I will be available to the Reference Committee to respond to questions.

The Headquarters Office

The operation of the KMA Headquarters Office is constantly undergoing change. KMA, in addition to its Headquarters in Louisville, now has an office in Frankfort which has proven to be extremely valuable, both during the legislative session and the Interim Committee sessions. KMA has become a conglomerate of ten separate but related corporations located in or operating out of the Headquarters Office: 1) the Kentucky Medical Association; 2) the Rural Kentucky Medical Scholarship Fund; 3) KEMPAC; 4) the Board of Medical Licensure; 5) the Auxiliary to KMA; 6) the McDowell House; 7) The Kentucky Postgraduate Medical Education Fund; 8) The Kentucky Foundation for Medical Care; and our newest two being: 9) the KMA Insurance Agency, Inc.; and 10) the Kentucky Medical Insurance Company. Our growth pattern over the years has been significant.

Activity Increases

While there is a total short-term commitment to lobbying activities during the Kentucky General Assembly, the legislation generated often creates long-term commitments which must be met by KMA and its staff. As one example, legislation this year resulted in the certification of paramedics and athletic trainers under the jurisdiction of the Board of Medical Licensure which is housed at KMA and administered by KMA staff.

The formation of the KMA Insurance Agency, Inc. and the Kentucky Medical Insurance Company was accomplished as the result of a sizeable effort by the KMA officers and Trustees, the KMA Insurance Agency Board, legal counsel, and staff.

Increased contact with our Congressional delegation was made this year and our efforts were generally successful. Cost containment received priority through our own Commission on Health Care Costs, and through staff and physician participation in the Kentucky Voluntary Effort for Cost Containment.

Numerous one-to three-day programs were conducted over the past several months including the Emergency Medical Care Seminar, Residents' Workshops, Medical Aspects of Sports Seminar, the Washington Dinner, approximately 15 Trustee District meetings, and the Annual Meeting in September.

In addition to meeting our daily commitments, staff has participated in national and regional AMA meetings, Leadership Conferences, Conferences on Medical Education, and Continuing Education for Medical Executives. Staff was proud to have had a part in a successful endeavor this year which encompassed about nine months of activity, climaxing in the June election of Hoyt D. Gardner, M.D. as President-Elect of the American Medical Association.

I am proud to have had the opportunity to participate at the international level as a member of a team that spent a week in England studying the British Health System. This past April the same team examined the Canadian National Health Service. These on-site studies have enabled Medicine to gain firsthand information helpful in our efforts to preserve the private practice of Medicine. This knowledge has been especially helpful in discussing the issue of National Health Insurance in newspaper and television interviews as well as in speeches to lay groups.

Finances

Some years back we adopted a five-year dues plan (raising dues only at five-year intervals). Our goal was to achieve a satisfactory level of liquid reserves. We are currently completing the third year of our present five-year plan. The 1978 financial audit is in your hands and speaks favorably for itself. Hopefully, our current five-year plan can be extended longer than anticipated before another dues increase is presented to you. We are trying to fight inflation with a tough "in-house" cost-effectiveness program, and feel our efforts have been successful.

Membership

Membership is at an all-time high. Although a prime objective of the Association is to be cognizant of the needs of the individual physician as well as the profession as a whole, not every decision or action can satisfy every member. Collectively we are making great strides forward and this results from an understanding membership. To be truly effective, Medicine must be cohesive. Achievement of this goal, which will result in our preserving as many freedoms as possible, will take work and understanding on everyone's part. Plans are being made to bring the county societies closer together, closer to KMA, and specific efforts are in progress to bring and keep the specialty societies under a strong and stable umbrella. Nationally, the budget of the entire Federation (counties, state, AMA, specialty societies) is over $200,000,000. Together we can be effective.

Where We Fit In the Health Care Industry

We recognize we are involved in a large and complex industry. It is the second or third largest industry in America with 4.67 million employees. It is a 180 billion dollar-a-year enterprise to which some 410,000 physicians devote their energies. More sophistication is now demanded even at the state medical association level, to properly serve such diverse ends. At KMA, demands increase daily and with them the need for more sophisticated technical assistance. Computerization may be part of the answer. The formalized continuing education of the medical society executive is now essential. Staff size must be continually assessed.

Summary

There are many physicians whom staff would like to thank. All of our officers have given unselfishly of their time. The entire Board of Trustees has had a challenging year. The Board has met a record number of times this year, usually tying two or three days together for Board meetings, Executive Committee meetings, Insurance Agency, Insurance Company Board, and Ad Hoc Committees.

Staff recognizes the sacrifices of the Board members, knows of their efforts, and observes their accomplishments. They are a group truly dedicated to their profession.

To the membership we say "thank you" for your support of staff. It makes our job much more satisfying to know we have the physicians of Kentucky with whom to work on a daily basis behind us.

Robert G. Cox, Executive Vice President

Recommendations, Reference Committee No. 1

The Committee next reviewed the Report of the Executive Vice President, Mr. Cox, and would like to, once again, thank him and his staff for their most capable assistance and for a job well done during this past year. The Committee recognizes the ever-increasing workload placed on him and his staff and appreciates the dedication shown through their many years of outstanding service to the KMA.

The Committee recommends this report be filed.

(The motion was seconded and carried.)

Report of the Advisory Committee to the KMA Auxiliary

The Kentucky Medical Association is indeed fortunate to have an Auxiliary that so heartily undertakes numerous activities that benefit medicine and the public.

The Auxiliary has again exceeded its goals, and we are proud to have a group of individuals who provide services so expeditiously.

Again this year funds collected by the Auxiliary for the AMA Education and Research Foundations, which are subsequently distributed to the University of Louisville and University of Kentucky Schools of Medicine, exceeded all previous years.

The Auxiliary and its officers should be proud of their achievements as we most certainly are. We hope more physicians' spouses will join and become active in the Auxiliary. As always the Auxiliary is a vital segment of organized medicine, and we are reassured that the Auxiliary will continue to provide invaluable service to the Association.

Fred C. Rainey, M.D., Chairman

Recommendations, Reference Committee No. 1

The Committee reviewed the Report of the Advisory Committee to the KMA Auxiliary and would like to thank Doctor Rainey for his report.

The Committee recommends that this report be filed.

(The motion was seconded and carried.)

Report of the County Society Presidents' Advisory Committee

The initial purpose of this Committee was fulfilled by a meeting and seminar for all county medical society presidents and representatives in 1977, and was reported to the House of Delegates last year.

This year saw intense KMA legislative efforts in Frankfort, the Washington Congressional visitation and dinner, the AMA Annual Meeting and campaign for AMA President-Elect, as well as the development and formation of KMA's own liability insurance company. These undertakings consumed a good deal of time and precluded a more active role by the Advisory Committee, except for routine contacts by the Board of Trustees.

Next year's President may ascertain new areas for attention by this group.

John P. Stewart, M.D., Chairman

Recommendations, Reference Committee No. 1

The Committee reviewed the Report of the County Society Presidents' Advisory Committee and would like to thank Doctor Stewart for this report.

The Committee recommends that this report be filed. (The motion was seconded and carried.)

Resolution C

KMA Board of Trustees

WHEREAS, in the laudable attempt to provide adequate medical care for all people, governments, and medical care intermediaries have not infrequently acted precipitously (if not capriciously) in establishing medical care programs and policies; and,

WHEREAS, the inevitable consequence of such actions have proven to be fiscally disastrous and often counter-productive; and,

WHEREAS, such agencies are characteristically not capable of admitting and remedying their own basic errors, but have inevitably sought to place the blame for their own foibles on extrinsic factors; and

WHEREAS, physicians, as a group, have provided a convenient and highly visible scapegoat for such failures of foresight and planning; and,

WHEREAS, as a result of this "scapegoatism", the ability of physicians to prescribe for and treat their patients as individuals (as opposed to computerized norms) is being constantly eroded and the physician is increasingly being harassed by restrictions not applied to any other profession or segment of the economy (including other "Health Care Providers"); and,

WHEREAS, there is no hope of redress from the legislative nor executive branches of government, be it therefore

RESOLVED, that the KMA establish a "Legal Trust Fund" with the following purposes and mechanisms:

The purpose of this Fund will be to support the legal efforts of any active KMA member to effect change of or gain redress from legislation, government regulations, or "third party" policies which, subject to the stipulations below, adversely affect the practice of medicine, patient protection, or physicians' rights either as individuals or professionals, **and the further purpose of this Fund will be to support participation by physicians or physician-oriented organizations in other legal efforts concerning matters of broad interest to or affect on the medical profession.**

Such support will be granted by the Trustee of the Fund only to those issues which have widespread or potentially widespread effects on medical practice, physicians' or patients' rights.

The Trustee of the Fund will be the KMA Board of Trustees.

The decision to support a cause may be made only after advice of KMA Counsel and will require affirmative vote of 3/4 of the KMA Trustees present and voting at a regularly scheduled meeting of the Board of Trustees. All such decisions will be final and unappealable unless, by unanimous consent, the Board votes to reconsider the matter at a later date.

Having underwritten a cause, the Trustee is obligated to continue its support to the highest judicial level possible consistent with the advice of KMA and plaintiff physician's counsel.

The support given should ordinarily cover all legal and physician expenses (vide infra) but may be less at the discretion of the Trustees.

The Fund will be provided by a $3 per annum assessment of the entire active KMA membership. Should the expenses exceed limits of the Fund in a given year, the Trustee may assess the KMA active membership for sufficient funds to carry litigation forward without interruption. This will be done as a special assessment, but will carry the same obligation as KMA dues.

Any physician **or organization** requesting support by the Trust Fund, must do so in writing at least six weeks before the next scheduled meeting of the KMA Board of Trustees. Such requests will immediately be forwarded to all KMA Trustees and to KMA Counsel for formulation of legal opinion.

All requests must clearly relate the cause of grievance and the principle(s) upon which the complaint is based—in language comprehensible to a (legalistic) layman.

Although not strictly necessary, it is advisable that any physician **or organization** applying for support from the Trust Fund consult his **or its** personal attorney for competent opinion of merits and practicality of legal action, and the preparation of the request prior to submission of that request.

If, in the opinion of the Trustee, the Trust contains sufficient funds for the projected need in the ensuing year, the per annum assessment shall be held in abeyance until such time as replenishment of the Fund shall be deemed necessary by the Trustee.

Funds from the Trust may be invested for capital growth as seems prudent to the Trustee, but monies must always be available to support the stated purpose of the Fund.

Trust funds will be used only to pay for legal costs and expenses of the physician(s) **or organizations** involved in the case. The physician expenses wll be restricted to travel, lodging and food costs incurred as a result of the litigation, and commensurate with business expenses ordinarily provided for KMA employees. In no case will involved physicians be reimbursed for time lost from practice.

If the outcome of litigation results in a monetary award to the plaintiff physician **or organization,** he **or it** must agree in advance that all funds provided by the

Trust in the conduct of the case will be repaid (interest free) up to the limits of the judgment—any surplus monies will belong to the plaintiff.

If the outcome of the litigation is adverse or results in no monetary award, the plaintiff physician **or organization** will have no financial obligation to the Trust Fund.

The Trustee is empowered to impose other administrative procedures and regulations as necessary to the administration of this Trust as long as such procedures and regulations in no way compromise nor contravene the principles embodied in this resolution.

The specific activities of this Trust will be reported to the KMA membership annually as part of the report of the President of the Board of Trustees.

Recommendations, Reference Committee No. 1

The Reference Committee No. 1 next reviewed Resolution C. After considerable discussion and with expressions by Doctor Caudill, KMA legal counsel, Mr. Carl Wedekind, members of the Board of Trustees and other Delegates of the KMA, it was the Committee's opinion that Resolution C be amended as follows:

WHEREAS in 1973 the House of Delegates passed Resolution Q establishing the Legal Trust Fund; and, WHEREAS certain changes are deemed advisable in the Legal Trust Fund, be it therefore resolved that Resolution Q, adopted in 1973, is hereby amended so that the resolutions as amended will read:

RESOLVED, that the KMA establish a "Legal Trust Fund" with the following purposes and mechanisms:

The purpose of this Fund will be to support the legal efforts of any active KMA member to effect change of or gain redress from legislation, government regulations, or "third party" policies which, subject to the stipulations below, adversely affect the practice of medicine, patient protection, or physicians' rights either as individuals or professionals, **and the further purpose of this Fund will be to support participation by physicians or physician-oriented organizations in other legal efforts concerning matters of broad interest to or affect on the medical profession.**

Such support will be granted by the Trustee of the Fund only to those issues which have widespread or potentially widespread effects on medical practice, physicians' or patients' rights.

The Trustee of the Fund will be the KMA Board of Trustees.

The decision to support a cause may be made only after advice of KMA counsel and will require affirmative vote of 3/4 of the KMA Trustees present and voting at a regularly scheduled meeting of the Board of Trustees. All such decisions will be final and unappealable unless, by unanimous consent, the Board votes to reconsider the matter at a later date.

Having underwritten a cause, the Trustee is obligated to continue its support to the highest judicial level possible consistent with the advice of KMA and plaintiff physician's counsel.

The support given should ordinarily cover all legal and physician expenses (vide infra) but may be less at the discretion of the Trustees.

The Fund will be provided by an annual assessment of the entire active KMA membership to be determined by the Fund Trustee but not to exceed $10.00 per year. Should the expenses exceed the limits of the Fund in a given year, the **Fund Trustee, with the consent of the House of Delegates,** may assess the KMA active membership for sufficient funds to carry litigation forward without interruption. This will be done as a special assessment, but will carry the same obligation as KMA dues.

Any physician **or organization** requesting support by the Trust Fund, must do so in writing at least six weeks before the next scheduled meeting of the KMA Board of Trustees. Such requests will immediately be forwarded to all KMA Trustees and to KMA Counsel for formulation of legal opinion.

All requests must clearly relate the cause of grievance and the principle(s) upon which the complaint is based—in language comprehensible to a (legalistic) layman.

Although not strictly necessary, it is advisable that any physician **or organization** applying for support from the Trust Fund consult his **or its** personal attorney for competent opinion of merits and practicality of legal action, and the preparation of the request prior to submission of that request.

If, in the opinion of the Trustee, the Trust contains sufficient funds for the projected need in the ensuing year, the per annum assessment shall be held in abeyance until such time as replenishment of the Fund shall be deemed necessary by the Trustee.

Funds from the Trust may be invested for capital growth as seems prudent to the Trustee, but monies must always be available to support the stated purpose of the Fund.

Trust funds will be used only to pay for legal costs and expenses of the physician(s) **or organizations** involved in the case. The physician expenses will be restricted to travel, lodging and food costs incurred as a result of the litigation, and commensurate with business expenses ordinarily provided for KMA employees. In no case will involved physicians be reimbursed for time lost from practice.

[No funds from the Trust may be paid to KMA employees nor to KMA counsel (including any firm of which he is a member or in which he has personal interest.)] DELETED.

If the outcome of litigation results in a monetary award to the plaintiff physician **or organization, he or it** must agree in advance that all funds provided by the Trust in the conduct of the case will be repaid (interest free) up to the limits of the judgment—any surplus monies will belong to the plaintiff.

If the outcome of the litigation is adverse or results in no monetary award, the plaintiff physician **or organization** will have no financial obligation to the Trust Fund.

The Trustee is empowered to impose other administrative procedures and regulation as necessary to the administration of this Trust as long as such procedures and regulations in no way compromise nor contravene the principles embodied in this resolution.

The specific activities of this Trust will be reported to the KMA membership annually as part of the report of the Chairman of the Board of Trustees.

Be it further resolved that the funds currently held in the existing Legal Trust Fund be considered as part of

this Legal Trust Fund as hereby amended to be managed in accordance with the terms of these resolutions.

The Committee recommends the adoption of Resolution C as amended.

The motion was seconded, following which considerable discussion ensued from the floor. A motion from the floor to include a specific maximum amount in the case of a special assessment was withdrawn. A motion to reinstate the following paragraph, the deletion of which had been recommended by the Reference Committee, was defeated:

"No funds from the Trust may be paid to KMA employees nor to KMA counsel (including any firm of which he is a member or in which he has personal interest)." It was pointed out by several House members that KMA's legal counsel would undoubtedly be more familiar with the background of any legal matter involving KMA, and retaining separate legal counsel would create an increased expense.

A motion was entertained from the floor to add the word "defendant" after the word "plaintiff" each time it appears in the Substitute Resolution, so as to read "plaintiff/defendant"; and to change the word "regularly" to "properly" as it appears in the sixth paragraph of the Substitute Resolution. The motion was seconded and carried.

Substitute Resolution C, as recommended by the Reference Committee, was then adopted as amended by the House.

Resolution V

KMA Board of Trustees

WHEREAS, Hoyt D. Gardner, M.D. has served the Jefferson County Medical Society and Kentucky Medical Association with distinction, and

WHEREAS, the KMA and Jefferson County Medical Society sponsored the candidacy of Hoyt D. Gardner, M.D. for the office of President-Elect of the American Medical Association, and

WHEREAS, Hoyt D. Gardner, M.D. was successful in his bid for that office, being elected President-Elect by the American Medical Association House of Delegates in June, therefore be it

RESOLVED, that this House of Delegates extend its congratulations to Doctor Gardner, express its pride in his accomplishments and wish him success in his future endeavors, both as President-Elect and President of the American Medical Association, and be it further

RESOLVED, that this action become a part of the permanent records and official proceedings of the 1978 Kentucky Medical Association House of Delegates.

Recommendations, Reference Committee No. 1

Reference Committee No. 1 reviewed Resolution V, introduced by the KMA Board of Trustees and would again like to congratulate Doctor Gardner on his newly elected assignment and look forward to his year of the Presidency of AMA with confidence and great anticipation.

The Committee recommends this Resolution be accepted.

(The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee Number 1 as a whole, as amended.

(The motion was seconded and carried.)

Mr. Speaker, as Chairman of Reference Committee No. 1, I would like to express my thanks to each of the Committee members present, Doctor Donald R. Neel, Doctor Wyatt Norvell, Doctor Carroll H. Robie for their help in preparing this report and to Mrs. Judy Hagler for her patience and understanding.

REFERENCE COMMITTEE NO. 1
N. H. Talley, M.D., Princeton, Chairman
Donald R. Neel, M.D., Owensboro
Wyatt Norvell, M.D., New Castle
Carroll H. Robie, M.D., Louisville

REFERENCE COMMITTEE NO. 2

Allen E. Grimes, Jr., M.D., Lexington
Chairman

Reference Committee No. 2 considered the following reports:

13. Report of the Scientific Program Committee
14. Report of the Scientific Exhibits Committee
15. Report of the Continuing Medical Education Committee
16. Report of the Cancer Committee
19. Report of the Hospital Committee
32. Report of the Emergency Medical Care Committee
36. Report of the Interspecialty Council
5. Report of the Chairman, Board of Trustees
   Special Report A—Continuing Medical Education, **only**

Report of the Scientific Program Committee

Your KMA Scientific Program Committee met this year in November to plan the Scientific Program for the KMA Annual Meeting. This amount of time is necessary to coordinate the 24 out-of-state speakers and 20 specialty society meetings which are a part of the Scientific Program.

In December, your Chairman met with the presidents of those specialty groups to discuss their participation in planning the scientific session. The scientific programs of the specialty groups held in conjunction with our General Session have proven time and again to be valuable, and we feel provide an excellent contribution to continuing medical education of the membership. I am extremely grateful for the excellent cooperation in planning the overall meeting that we have received from the specialty groups.

The 1978 Annual Meeting marks the first time in recent memory that the Annual Meeting has been held outside of Louisville. As the Scientific Program Committee's objective is to present an appealing and educational program that will provide maximum benefits to the members of KMA, we feel the excellent meeting facilities and pleasant surroundings of the Hyatt Regency offer a most attractive incentive for attending the 1978 Annual Meeting.

The Scientific Program this year will feature a mix of subjects of current interest and will include half-day sessions on the topics "pulmonary disease" and "endocrine problems." The Committee members and specialty groups have gone to great lengths to bring in some of the country's most outstanding speakers. We are proud of the fact that KMA's Annual Meeting Scientific Program continues to be one of the best state meetings in the country. It is accredited for continuing education by the American Medical Association and the Kentucky Academy of Family Physicians, among others.

An innovation of the 1978 Meeting will be the presentation of an eight-hour course on cardiopulmonary resuscitation presented by the Kentucky Heart Association. Those successfully completing the course will be certified by the Heart Association in basic life support.

As Chairman of the Scientific Program Committee, I am most appreciative of the efforts of those who assisted in the formation of this program, particularly the Committee members, specialty group presidents, and specialty program chairmen.

As always, suggestions from the membership for future programs are very welcome.

Richard F. Hench, M.D., Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the Report of the Scientific Program Committee and commends the Committee for its outstanding program this year. We would like to commend the Kentucky Heart Association for presenting its course on CPR. The Committee also wishes to express its thanks to the Kentucky Chapter of American Association of Medical Assistants for sponsoring the Message Center this year.

Reference Committee No. 2 recommends that the Report of the Scientific Program Committee be filed.

(The motion was seconded and carried.)

Report of the Scientific Exhibits Committee

Due to scheduling conflicts, the Scientific Exhibits Committee was unable to meet formally this Associational year. However, the 1978 Exhibit Hall provided us with more scientific exhibit space than we normally have, thus providing approved exhibitors their requested space. All functions of the Committee were handled by telephone and correspondence, and this was found to be satisfactory by members of the Committee.

The 1978 Annual Meeting will have 14 scientific exhibits set up with drapery walls rather than hardback walls to decrease expenses. The exhibits will be located along the entrance to the General Assembly Hall to provide maximum exposure to those in attendance.

The Committee will meet and judge each individual exhibit and award Certificates of Achievement to those exhibitors displaying outstanding efforts to achieve the highest teaching value. The Committee will also present Certificates of Participation to each exhibitor for his participation in our Annual Meeting.

The Committee believes that the Scientific Exhibits are an integral part of the Annual Meeting activities and provides a valuable contribution to post-graduate physician education. We strongly urge all members in attendance at the Annual Meeting to visit and learn from these worthwhile endeavors.

Richard A. Kielar, M.D., Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the Report of the Scientific Exhibits Committee and expresses thanks for the excellent quality of scientific exhibits. The Committee feels that the scientific exhibits are a great educational asset, and we wish to encourage increased participation in the future.

The Reference Committee recommends that the Report of the Scientific Exhibits Committee be filed.

(The motion was seconded and carried.)

Report of the Continuing Medical Education Committee

The CME accreditation process was the focus of the Committee's major actions this year. The Committee, along with the Board of Trustees, watched the transfer of accreditation authority from the AMA to the Liaison Committee on Continuing Medical Education with some concern. These concerns were finally resolved through the discussions of the LCCME by the AMA House of Delegates, but during that period, KMA's own accreditation activities were delayed. In line with LCCME efforts, state medical associations were requested to establish the members of their CME committees along the lines of the LCCME member organization makeup. The Committee, therefore, requested that representatives from the Board of Medical Licensure, the Kentucky Hospital Association, and the National Board of Medical Specialties meet with it as guests or ex-officio members. The LCCME is made up of representatives from the AMA, the American Hospital Association, the Board of Medical Specialties and the Federation of State Licensing Agencies.

At the request of the Board of Trustees and several members, the Committee has begun to reevaluate the accreditation process and try to streamline it. A subcommittee was appointed to work on this project, and has been meeting. Hopefully, more information on this will be forthcoming in the Fall.

In the accreditation process for this year, one application is pending, one accredited group is due for resurvey, and new accreditation has been awarded to one facility.

It was noted that the accreditation of KMA's Annual Meeting is due for resurvey this year, and an AMA survey team will be visiting and observing the Annual Meeting this September.

In an effort to make more general information available, the Committee is working on a project to periodically publish in the *KMA Journal* new procedures and clinical applications in the various specialties. These plans call for consulting with the various groups in determining what new procedures or innovative treatments have developed that have day-to-day usefulness in a physician's office and, hopefully, a series of such articles will be forthcoming.

Another area that is being explored is evaluation of medical foundations. The Utah Medical Association has

established such a foundation, which is responsible for some very affirmative CME efforts in that state, and the Committee is in the process of reviewing the Utah plan in detail.

While a number of factors have delayed the Committee's activities, such as concern with the LCCME efforts, a number of new plans have been made, and we look forward expectantly to the coming year's work.

D. Vertrees Hollingsworth, M.D., Chairman

Report of the Chairman, Board of Trustees

Special Report A Only

During the 1976 session of the House of Delegates a position was adopted to support voluntary participation in continuing medical education, and KMA was directed to provide a mechanism for recording this participation.

This year marks the second year that this records keeping system has been in effect.

As reported previously, the reporting form parallels the reporting requirements for the AMA Physician Recognition Award, because this same format has essentially universal acceptance by most all CME organizations.

Some of the aspects of this reporting procedure, as announced in the *KMA Journal* and "Communicator," are that it should be most convenient for the reporting physician, should not duplicate reporting requirements for other records keeping organizations, and is intended as an indirect encouragement for CME participation.

The reporting period for this information is August 31, 1977 to August 31, 1978. A summary of the information reported follows:

Reporting Period: 8/77 - 8/78 (or one year)
Number of Eligible Members: 3378 Age Range: 27-84
Number of Responses: 673 Mean: 50 years
Percent Responding: 20% (.1992)
Average Hours Per Physician: 103 (103.06)

Categories	Average	Total Hrs. Reported
I	43.55	23509.5
II	8.69	7822.5
III	16.70	6020
IV	4.68	1688
V	29.44	13738

The material indicates that physicians, on an average, are accumulating more hours of CME than are required annually for the AMA's PRA; 103 hours as opposed to 50.

As reported, the majority of hours seem to be spent in Category I; that is, CME activities with accredited sponsorship; with Category V, nonsupervised individual CME activities, being the Category next most often occurring. It is interesting to note that Categories II, CME activities with non-accredited sponsorship; and IV, papers, publications, books and exhibits; have the least amount of participation. Category III, medical teaching, shows a relatively high amount of participation in comparison with Categories II and IV.

In analyzing the data available, consideration should be given to a number of uncontrolled variables. These are that:

—The reporting of CME hours in different categories was not consistent. It was obvious that some hours were reported in the wrong categories. The reporting was not standardized.

—Some of the hours reported for Category I may not have been bona fide Category I credits, but rather were hours accumulated in Category I *type* programs.

—Some of the credit hours claimed were extrapolated from aggregate data; i.e., the hours weren't reported in a form that could be translated easily into individual CME units.

It is evident from the reporting forms that many hours were spent in various categories that weren't reported, and it may, likewise, have occurred that some hours were reported that weren't actually accumulated. Because of these variables, a statistically weighted average was applied to try to standardize all hours reported.

An additional response was added to this year's reporting form, which asked for the respondent's age, because of the implication that age might directly relate to the degree of CME participation, and this was apparently the case.

An interesting comparison can be made with similar figures reported last year. Briefly, the average number of hours per physician was the same, 103. Likewise, the average number of hours per physician for each category of CME was also comparable. These figures for each of the categories are as follows:

Categories	1977	1978
I	39.54	43.55
II	9.83	8.69
III	18	16.70
IV	8.519	4.68
V	27	29.44

Although the percentage of those responding to the questionnaire was less this year, the total number of eligible responses increased somewhat. Given these comparisons, it is probably valid to say that participation has been consistent, at least for the last two years.

The information gathering process, collation and interpretation methods of this system can be challenged from the standpoint of scientific validity. However, the intent of the records keeping system has been served; this information does effectively document substantial voluntary participation in CME by Kentucky's physicians.

The membership is enocuraged to maintain records on CME participation and to report them to KMA in following years, so that this documentation can be ongoing.

Recommendations, Reference Committee No. 2

The Reference Committee reviewed and approved the combined reports of the Continuing Medical Education Committee and Special Report A, Report of the Chairman of the Board of Trustees. The Reference Committee wishes to commend the Continuing Medical Education Committee for their hard work in performing surveys as part of the accreditation process. The Committee reviewed with optimism the project to publish in the KMA *Journal* new procedures and clinical applications in the various medical specialties. All specialties are urged to

cooperate with this project. The Committee notes the 20% response on the part of Kentucky physicians in reporting their CME participation and would like to urge all physicians to accurately maintain such records.

The Reference Committee recommends that the Report of the Continuing Medical Education Committee and Special Report A of the Report of the Chairman of the Board of Trustees be filed.

(The motion was seconded and carried.)

Report of the Cancer Committee

During the past year, the KMA Cancer Committee has met at three-month intervals. A summary of the actions taken by this Committee is as follows.

As a particular approach to the increasing seriousness of cancer of the lung, the Committee recommended to the Board of Trustees that the profession endorse efforts to urge young children not to smoke through anti-smoking educational efforts. The Kentucky Division of the American Cancer Society will emphasize this in each county unit in the state.

Extensive discussions relating to the reestablishment of a state cancer registry have included consultative meetings with the Bureau for Health Services, the University of Louisville School of Medicine and the University of Kentucky College of Medicine. The two Cancer Center Directors met with Doctor Hernandez and discussed the undertaking thoroughly. It was noted by the Committee that previous efforts to maintain a statewide registry were not successful, probably due to the lack of understanding of the necessity and publicity among the physicians of the state. This present Committee recommended to the Board of Trustees that the KMA endorse a central registry of the Department for Human Resources. It was the desire of the Committee that both Universities be asked to cooperate and to offer constructive advice in the formation and activities of such a statewide cancer registry.

The Committee reviewed the report of the American College of Surgeons in regard to a study of cancer of the colon. This is one of the most common of all cancers, and less than one-third are being detected at an early, potentially curable stage. Only slightly more than one-half of the patients survive five years. Results of treatment are essentially similar in hospitals throughout the country, regardless of their size and location. It was noted that digital rectal examinations were not reported in almost 20% of hospital charts, that proctosigmoidoscopy was performed on less than 60% of the patients with colon cancer, and that barium enemas apparently were not obtained in 15%. The Committee recommends that the profession attempt to improve this situation.

At each meeting, reports regarding the progress of the Ephraim McDowell Community Cancer Network in Lexington, and the Regional Cancer Center in Louisville, have been received with great interest and with encouragement in each instance to proceed in their developments.

The Committee endorsed the BENT Program concerning the risk of radiation from mammography, and also commended Doctor Maruyama's work concerning the risk of irradiation and radiation in general.

The Committee also reviewed cancer-related legislation, especially those Bills regarding Laetrile and the establishment of a Cancer Commission.

The Committee is pleased with the one-page articles submitted to the Editorial Board of the *Journal* and expects to have more informative reports for their consideration in the future.

Discussions have continued in regard to environmental factors in cancer, especially drinking water. In the immediate future it appears that rather severe regulations may be issued by the Environmental Protection Agency. The Committee will continue to study this problem in some detail.

The various educational programs promoted and underwritten by the Kentucky Division of the American Cancer Society and those of the two University Medical Schools have been reviewed by the Committee and are highly commended. The efforts of the Cancer Society to establish Cancer Update in the Parks, in a series of six meetings during this spring, have been disappointing in attendance. However, the Cancer Society is encouraged to reevaluate this at the conclusion, and to realize that time may be required to make this a popular and highly instructive method of education. Constructive information may have a great impact, even if only a few physicians are able to be present.

The Committee endorses the concept and desirability of a one or two-day meeting held at each of the University Medical Schools for the entire profession, perhaps on alternate years or alternate six-month intervals. Also, the Cancer Committee will attempt to provide programs for medical societies and hospital staffs, particularly in cooperation with the American Cancer Society, as may be desired.

The Cancer Committee realizes that unusual new opportunities are appearing for the treatment of the cancer patient from the results of new research, the activities of the two Universities with their respective Cancer Centers, and the role of professional and public education by the American Cancer Society.

The impact of new legislation, which will establish a Cancer Commission for the state of Kentucky, is as yet undetermined by the Committee, but it represents a potent and important source of leadership and activity in this field. The Cancer Committee of the KMA wishes to cooperate in every way possible with the new Commission.

Laman A. Gray, Sr., M.D., Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the report of the Cancer Committee and commends that Committee on its report. We agree with the endorsement of the state-wide cancer registry to be maintained by the Department for Human Resources. It is hoped that all facilities within the state dealing with cancer can be coordinated in the state. The various educational programs of the two medical schools and the American Cancer Society are to be commended. It is hoped that the newly established Cancer Commission will provide an important source of leadership and coordination in the state.

The Reference Committee recommends the filing of this Report.

(The motion was seconded and carried.)

Report of the Hospital Committee

The major thrust of your Hospital Committee this year has been to continue the development of both a simplified in-hospital appeals mechanism for hospitals with small medical staffs, as well as a voluntary non-binding arbitration mechanism whereby individuals who had exhausted the various methods of appeal within the hospital structure could call on KMA for additional comments.

A considerable amount of time has been spent on the development of the simplified appeals process, and a model has been approved by both the KMA Board of Trustees and the Board of Directors of the Kentucky Hospital Association. Although the Committee is hopeful that their suggestions will be helpful to small hospitals, we certainly did not wish to have a hospital accept a plan that would be unacceptable to the Joint Commission on the Accreditation of Hospitals. For that reason, we have withheld circulation pending approval of the Joint Commission. The Committee notes that the Joint Commission has changed its philosophy of providing model Bylaws for hospitals to that of offering guidelines for the hospitals to follow in the development of their Bylaws.

In our discussion of the voluntary non-binding arbitration mechanism, the Committee felt that ideally such a program would be beneficial in certain cases. However, it was the Committee's feeling that in practicality, time limitations and legal implications would make the program difficult to implement, and for that reason feels that further development of the concept is unfeasible at this time.

We are pleased to report that the "Dry Run" Teams continue to be active. The Teams were set up in 1962 to help hospitals seeking accreditation for the first time to prepare for accreditation by the Joint Commission on the Accreditation of Hospitals. Experienced physicians, hospital administrators, medical records librarians, and nursing service supervisors have served faithfully on these teams for the past sixteen years and have provided most beneficial service.

Cost containment continues to be of interest to the Committee, and we were pleased to learn that in addition to KMA's Commission on Health Costs, KMA is also participating in the Voluntary Effort on Cost Containment which, nationally, is a joint venture of the AMA, AHA, and Federation of American Hospitals.

The Chairman would like to thank the membership of this Committee, and the representatives from the Kentucky Hospital Association who have met with us, for their help and participation.

Royce E. Dawson, M.D.
Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the report of the Hospital Committee. The "Dry Run" Teams, which help hospitals seeking accreditation for the first time, are to be commended for their continuing efforts.

The Reference Committee recommends that this Report be filed.

(The motion was seconded and carried.)

Report of the Emergency Medical Care Committee

Your Emergency Medical Care Committee met on November 30, 1977 to get a status report on emergency medical services in the state of Kentucky and to plan the Eighth Annual KMA Emergency Medical Care Seminar, which the Committee presented in June, 1978.

A representative from the State Department for Human Resources, Emergency Medical Services Branch, attended our meeting in November to update the Committee on the current status of Kentucky's EMS Program. The Committee learned that the Department was busy at work establishing procedures for use throughout the state when patients are transferred from one facility to another. Concern was expressed that the development of such protocols might eventually be considered standards of care. The Committee recommended that two separate protocols be developed, one for physicians, and the other for EMTs. The physician guidelines, the Committee felt, should be of a general nature, while the EMTs' protocol should be more narrowly defined. The Committee also recommended that medical specialties be consulted in the development of those guidelines.

The Committee also heard a report on the status of the Fort Knox MAST Program. In the three and one-half years the service has been in existence, 1,300 missions have been flown. The program has been well-received in Kentucky and several rural hospitals are strongly considering the construction of helipads. A considerable amount of effort has been expended in making individuals aware of how to utilize the service and it was pointed out that the service can be used not only for transfers within Kentucky, but transfers from Kentucky to other states as well.

The major undertaking of the Emergency Medical Care Committee this year was to again plan and implement the Eighth Annual Emergency Medical Care Seminar which was held June 7-8-9, at the Executive West, Louisville. The program was held this year in conjunction with the State Department for Human Resources, Bureau of Emergency Medical Services' EMS Conference, and 416 people registered for the combined meeting.

Two afternoons were devoted to the presentation of a basic life support program given by the American Red Cross. Those successfully completing the course are certified by the Red Cross in basic life support. The Committee is deeply indebted to the many voluntary instructors who participated in presenting the course. Response to that segment of the program was again extremely favorable and we were very pleased to have been able to make it a part of the Seminar.

The Committee is also indebted to the number of physicians and other faculty members from around the state who gave freely of their time to come and serve as instructors on the program. The small registration fee charged by the Committee covers the cost of meals and other promotional expenses, and enables us to allow many people to attend.

We were pleased to have as featured luncheon speakers, Mr. John D. Hoyle, Fort Thomas, and Doctor John S. Farquhar, Evansville, Indiana. Both of these gentlemen made outstanding contributions to the success of the meeting.

One full morning session was dedicated to the "High Risk Newborn" and we were fortunate to have the mobile intensive care unit from Children's Hospital displayed at the meeting.

This year's program was accredited for continuing education by the American Medical Association; Kentucky Chapter, American College of Emergency Physicians; Kentucky Academy of Family Physicians; Kentucky Dental Association; the Kentuckiana Chapter, Emergency Department Nurses Association; and the American Registry of Emergency Medical Technicians. The Committee enthusiastically recommends that the Seminar be held again next year with the Emergency Medical Care Committee being the coordinating agency.

This year's seminar was dedicated to the memory of William J. Carey, M.D. Doctor Carey died in January of this year at the age of 46. He had been a member of the Emergency Medical Care Committee for several years and was one of the prime movers in emergency services in Kentucky, and was an active participant in KMA's Emergency Seminars since its inception.

The members of the Committee have given freely of a considerable amount of time and effort this year and I express my sincere appreciation to them.

E. Truman Mays, M.D.
Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the report of the Emergency Medical Care Committee and its excellent job and continuing education program. The Committee also wishes to commend the military MAST Programs in the state and hopes that they can be expanded in the future.

We recommend that this Report be filed.

(The motion was seconded and carried.)

Report of the Interspecialty Council

The Interspecialty Council represents 21 different specialty societies in the State. Although the Council has been inactive for the past couple of years, it is nonetheless considered to be an important contributor to the betterment of organized medicine in Kentucky.

Several meetings were held during the course of this past year. At the first meeting the Council discussed how communications between the KMA and specialty societies could be improved. It was the Council's opinion that not enough information was being provided to the Specialty Societies on major issues confronting the Association, for example, legislation, governmental regulations and some of the day-to-day activities of the KMA.

The Board of Trustees was informed of these problems and to help increase the flow of information, the Board now includes all specialty group officers on its mailing list for all important correspondence, including the "Legislative Bulletin" and the "Open Line" (Board of Trustees Newsletter). In reciprocating action, representatives on the Council pledged to keep the KMA more readily informed of their concerns and problems by conveying them through staff to the Board of Trustees. If communications can be maintained many of the problems that have resulted in the past can be avoided.

At the November meeting the Council received a briefing on the prefiled legislation that was to be considered by the 1978 General Assembly. The Council collectively formulated their view points on this legislation and other legislation that was expected to be introduced, and forwarded their comments to the Committee on State Legislative Activities for their consideration. However, not all specialties were represented at this meeting and communication problems occurred which resulted in minor complications in providing a unified effort on medicine's behalf in Frankfort. This was of concern to many and at the second meeting of the Council, held after the General Assembly had adjourned, Doctor Carl Cooper, Chairman of the State Legislative Activities Committee, met with the Council to determine if a more unified approach to legislative activities could be developed for future use. Doctor Cooper recommended, and the Council agreed, that the Specialty Group should meet in conjunction with the State Legislative Activities Committee, prior to the next legislative session, to review and develop legislation for introduction to that session and to establish an appropriate plan of action for their passage. It is hoped that this unified cooperation will greatly enhance our efforts in Frankfort.

Another concern of the Interspecialty Council that developed out of this recent legislative session was that of a lack of medical input into the development of health programs and regulations in Kentucky. Many problems have developed in the past especially in the legislative arena, where legislation is introduced and sometimes passed, that is counterproductive to medicine and the public. To address this problem, which is one that the whole Association faces, the Council decided to invite a representative from the Secretary of the Department for Human Resources office to answer this question and others that the Council had. The Council was fortunate to have Mr. Robert Slaton, who at that time was Senior Administrative Assistant of DHR, and who is now currently the Commissioner of the Bureau for Health Services, attend this meeting. Besides the numerous questions presented to Mr. Slaton, one underlying problem still remains and that is the need for adequate medical input into health programs before they are implemented. Mr. Slaton agreed that there was a need for more medical input and it is hoped that through the new chief medical officer for the State, and with assistance by the KMA a more workable relationship can be developed. It was further stated through Mr. Slaton, that the Secretary of DHR wanted to work more closely with the Association and specialty groups in developing more workable programs. Also, if any specialty society does develop problems with a certain health program, it was stated by Mr. Slaton that he and his office would be willing to meet with representatives of that society to try and work out the complications.

The Council wishes to express its thanks to Commissioner Slaton for taking time from his busy schedule to meet with us and we hope that the lines of communication established at this meeting will continue to stay open as we continue to strive for a better working relationship between government and medicine.

This year the Council has been striving to reestablish the two way flow of information between the KMA and itself. By doing this it is hoped that both of us will be

able to obtain more nonduplicative and productive results. I want to thank the various representatives of the Specialty Societies who attend the meetings and strongly encourage those who were unable to attend to do so in the future.

Stephen B. Kelley, M.D.
Chairman

Recommendations, Reference Committee No. 2

The Reference Committee reviewed the report of the Interspecialty Council and looks with optimism at the resumption of the activities of the Interspecialty Council. It feels that the communications between KMA and the specialty groups are of increasing importance. It is felt that it is vital to increase medical input to development of health programs in Kentucky.

The Reference Committee recommends that this Report be filed.

(The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 2 as a whole. (The motion was seconded and carried.)

Mr. Speaker, I would like to thank the members of the House of Delegates and the members of this Reference Committee for their help and careful deliberation of the matters brought before this committee and Mrs. West for her help in preparing the report.

REFERENCE COMMITTEE NO. 2
Allen E. Grimes, Jr., M.D., Lexington, Chairman
Keith E. Ellis, M.D., Benton
Paul J. Sides, M.D., Lancaster
Donald T. Varga, M.D., Louisville

REFERENCE COMMITTEE NO. 3

Charles C. Smith, M.D., Louisville
Chairman

Reference Committee No. 3 considered the following reports and resolutions:

17. Report of the Maternal Mortality Study Committee

21. Report of the Committee on Occupational Health and Environmental Quality

25. Report of the Committee on National Legislative Activities

26. Report of the Committee on State Legislative Activities

37. Report of the Committee on Physicians' Health

Resolution G—Kentucky Senate Bill 94 (1978) (Joseph G. Whelan, Jr., M.D.)

Resolution H—Kentucky Administrative Regulation 902 KAR 105 (Joseph G. Whelan, Jr., M.D.)

Resolution K—Certificate of Need (Floyd County Medical Society)

Resolution N—Kentucky Administrative Regulation 902 KAR 105 (Bullitt County Medical Society)

Resolution O—Certification of Physician's Assistants (Tri-County Medical Society)

Resolution T—Local Government Ordinance Regulating the Practice of Medicine (Jefferson County Medical Society)

Resolution W—Kentucky Medical Insurance Company (KMA Board of Trustees)

Resolution X—AMA National Health Insurance Bill (KMA Board of Trustees)

Report of the Maternal Mortality Study Committee

The Maternal Mortality Committee of the Kentucky Medical Association met twice during the Associational year, once at the time of the Annual Kentucky Medical Association meeting in September of 1977 and again at the time of the Kentucky Obstetrical Gynecological Society in June of 1978; maternal deaths were reviewed and a classification made of each case by the Committee. Reports of worthwhile teaching cases are reported intermittently in the *Journal*.

John W. Greene, Jr., M.D., Chairman

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed the Report of the Maternal Mortality Study Committee and is aware of the good work being done by this Committee.

The Reference Committee does, however, recommend that each year the Maternal Mortality Study Committee report on the incidence of maternal deaths and give some comparison with the previous years' statistics. We are also aware of the problem of the individual physicians involved with the deaths not meeting with the Maternal Mortality Study Committee, and we would recommend that the Association urge that this be done. To facilitate the attendance of the physician involved, we would recommend that he be invited in each case with a copy of such invitation to be sent to the chief-of-staff of the hospital involved.

Reference Committee No. 3 recommends that the report be accepted with these recommendations.

(The motion was seconded and carried.)

Report of the Committee on Occupational Health and Environmental Quality

This Committee has not been very active this year. All the members of the Committee were contacted by letter in October, 1977, asking for their thoughts about any matters which should be presented before the Committee. There was no response to this inquiry.

As Chairman of the Committee, I attended three Environmental Protection Agency meetings in Frankfort during the year. I also participated in some of the meetings here in Louisville which had to do with the proposed regulations concerning water purification for trihalomethanes.

The one meeting that we did have was on April 12, 1978, and the major topic concerned whether this Committee and the Kentucky Medical Association should go on record opposing EPA proposed regulations. Since there were only four members present at this meeting, I declined to take an official stand.

I feel there are many proper projects in which this Committee could become involved in the State of Kentucky, but it seems that we have a hard time getting any particular project under way.

B. Frank Radmacher, M.D., Chairman

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed the Report of the Committee on Occupational Health and Environmental Quality. We feel this should be maintained as a committee to meet when specific occupational and environmental problems arise.

Reference Committee No. 3 recommends that the report be filed.

(The motion was seconded and carried.)

Report of the Committee on National Legislative Activities

Increasing legislative attention to health matters in Washington has resulted in an increase in KMA's national legislative activities and, fortunately, with some effect.

Medical care cost containment has been a central issue of this session of the 95th Congress, as well as receiving a great deal of attention from the Administration. Representative Paul Rogers, Chairman of the Health Subcommittee of the House Committee on Interstate and Foreign Commerce, has been the central figure recently of cost containment legislation, and the Bill he favors reflects the Administration's intents to a large degree.

The essentials of H.R. 9717 would recognize the Voluntary Effort, a program initiated by the American Hospital Association, AMA and the Federation of American Hospitals, which calls for all aspects of the medical care field to voluntarily attempt to reduce increases in cost by 2% a year, for the next two years. If the Voluntary Effort is not successful, a mandatory 9% cap on costs would go into effect, as would a cap on capital expenditures for all health care facilities.

A key figure in discussions of this Bill is Fifth Kentucky Congressional District Congressman Tim Lee Carter, M.D., who is ranking Republican on Mr. Rogers' Subcommittee. KMA's work on this Bill alone has included three personal visits to Doctor Carter, as well as numerous letters and telegrams to him and other Congressional figures, spanning the past six to eight months. As of the time of this writing, the outcome of the Bill is still uncertain.

Two other related major proposals during this session have been S. 2410 and S. 2534. Both Bills relate to amendments to the Health Planning Act and to HMO's. Both Bills include provisions for placing physicians' offices under Certificate of Need authority, and S. 2534 would exempt HMO's from Certificate of Need authority if physicians' offices were exempt. Doctor Carter has been involved in Certificate of Need for the past year, and Kentucky was very fortunate in having Senator Walter Dee Huddleston author an amendment to S. 2410 that would exclude physicians' offices from CON. This Bill also resulted in at least two personal visits in Washington with Senator Huddleston and Doctor Carter, and again, KMA initiated many telephone calls, telegrams and letters on various aspects of the legislation.

The third subject of a good deal of attention has been S. 3105, the Catastrophic Health Insurance and Medical Assistance Act of 1978. As of this writing, this Bill, too, is pending. It would provide catastrophic health insurance coverage to all citizens, with a $2,000 out-of-pocket entry point, and would federalize the Medicaid Program. The insurance proposal would be funded by a 1% payroll tax on all employers, and employers could either provide employees with this coverage, or opt for similar coverage through federally certified private health insurors. KMA has monitored this Bill, too, very closely. A number of other bills have been closely followed, and they run the gamut from the FDA's drug approval process, to revisions to the federal rule-making process.

In addition to legislation, KMA has routinely followed the activities of federal health regulatory agencies and has monitored and commented on a number of proposed rules and regulations. Probably the major regulatory issue this year was the publication of proposed National Health Planning Guidelines, which listed a minimum hospital bed capacity rate and minimum specialty service procedures required. KMA's efforts, together with those of many other organizations, resulted in these Guidelines being at least temporarily withdrawn. We were joined in our opposition by most of Kentucky's Congressional Delegation, who were contacted on the subject.

From an organizational standpoint, the Committee agreed at its first meeting to meet only as needed, because most of the issues KMA becomes involved in at any time are of such an urgent nature that a Committee meeting is not possible. Instead, Committee activities would be carried on through individual Committee members who are Key Men to Kentucky's Congressmen, and we feel this has been fairly effective. This situation seems to be the most helpful, because legislative issues change so rapidly in Washington; yet personal contacts of Legislators by physicians are very worthwhile.

The Washington Dinner was held this year at the Committee's request, and was quite successful. Each of the Congressmen was visited at least one time in his office, and all were present at the dinner or were represented by family members or top aides. The dinner and visitation were timely, because they took place when some of the key legislative issues mentioned were undergoing discussion or hearings. Twenty-five physicians and their spouses were able to attend the dinner. The value of the visitations and dinner cannot be overemphasized, as this presents a unique opportunity to discuss key legislative issues and, at the same time, to socially thank our Legislators for their efforts.

Some recognition is in order for the efforts of the AMA Washington Office, which is headed by Mike Riley. Doctor John Zapp heads the Congressional lobbying department, and both men and their staffs do an excellent job in keeping abreast of legislation and presenting medicine's views.

A word of thanks is also in order to each of the Key Men for their contributions, which are often hectic and usually at inconvenient times.

Fred C. Rainey, M.D., Chairman

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed the Report of the Committee on National Legislative Activities and wishes

to commend the Committee for a job well done. We also feel that the Washington Dinner should be continued on an annual basis.

Reference Committee No. 3 recommends this report be filed.

(The motion was seconded and carried.)

Report of the Committee on State Legislative Activities

The adjournment of the 1978 General Assembly culminated a very intense effort by the Committee on State Legislative Activities on behalf of the KMA membership. Numerous meetings by members of the Committee were held in regard to legislation introduced during the session, and the major legislative concepts approved by the 1977 House of Delegates became law.

KMA's main legislative goal, as designated by the House of Delegates, was the Confidentiality of Peer Review (SB 255). We were successful in seeing SB 255, along with HB 555 sponsored by one of our members, Representative Jack Trevey, M.D., Lexington, enacted. House Bill 555 strengthens the authority of the State Board of Medical Licensure. Another major objective was to seek legalization of the Physician Assistant; however, the Physician Assistant Bill again ran into several obstacles, and amendments restricting the mobility of the PA prevented us from supporting the final legislation. The bill died on the final day of the General Assembly.

The Committee on State Legislative Activities followed 126 proposed bills, many of which were opposed as being detrimental to the public health. On the defensive side, we lost on three major battles. The chiropractors, after many years, were able to obtain passage of legislation authorizing them to treat job-related injuries. Kentucky thus became the 50th state to authorize this practice under Workmen's Compensation. The optometrists were successful in the passage of the "Drop Bill," which allows them to use diagnostic drugs. Finally, legislation passed that grants the Department for Human Resources new authority to license and levy fees and to monitor the users of radioactive machines and radioactive materials.

During the 1978 session, the Frankfort KMA office was open full time and provided excellent service to the Committee and interested KMA members. We again used Frankfort legal counsel to assist in the lobbying activities. Both these services were invaluable in our ability to stay on top of the General Assembly activities. We recommend that these services be retained for the 1980 session of the General Assembly. These two services, under the guidance and direction of the Louisville office, provide a very cohesive and excellent working relationship.

The Committee met again on July 19, 1978, to review KMA's effort in 1978 and to map out strategy for the 1980 General Assembly. We plan to formulate and distribute to Key Men and other interested physicians items that we expect to be major legislative efforts in the 1980 session. Already there have been several proposals made for the inclusion of physicians' offices under Certificate of Need. Legislation introduced in the 1978 session, which was killed in the House Committee on Health and Welfare, would have severely restricted the practice of hospital-based physicians, and this legislation may again be introduced in the 1980 General Assembly. Legislation to remove most providers of health services from governing boards of health-related institutions and government services will probably surface, along with attempts in other health-related fields to expand practice into those areas normally designated for physicians.

The 1978 session has been a sobering experience to the Committee on State Legislative Activities and other physicians involved with the legislature, and the 1980 session promises to be very interesting. The Committee on State Legislative Activities urges all members of the KMA to become involved in the local political arena. This involvement must not stop with monetary contributions, but should be accompanied with active support for the candidates of your choiec.

As Chairman of the Committee on State Legislative Activities, I wish to personally express my gratitude and appreciation to the members of the Committee, the Board of Trustees and the Executive Committee who served so well and so unselfishly during the year. Without their strong personal support and encouragement, our successes would not have been possible.

Carl Cooper, Jr., M.D., Chairman

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities, and we want to commend the Committee for a job well done.

Reference Committee No. 3 recommends this report be filed.

(The motion was seconded and carried.)

Report of the Committee on Physicians' Health

The Committee on Physicians' Health has not had any formal activity this year, but has provided consultation on several occasions to individuals and groups who were aware of, or had problems with, impaired physicians.

Our concern continues with the absence of impaired physicians being identified. Based on personal knowledge of the Committee members in discussion with other physicians, it seems likely that many are not being reported. The Committee does not intend necessarily to be a central reporting or referral source, but has received much fewer indications of the actions of impaired physicians than we suspect exist.

It should be pointed out that the purpose of the Committee is not to act in any punitive fashion, but rather to help those physicians with illnesses, impairments and substance abuse problems, to recognize their conditions and then try and work to resolve them. It is the unfortunate, but very necessary task of peers, family members and friends to acknowledge impairments to affected physicians, as well as to our group. Only when such situations are singled out for scrutiny can any work begin to resolve them.

Our Committee will be represented at the Third National Conference on the Impaired Physician scheduled for September 29 - October 1. The Conference is sponsored by the AMA Department of Mental Health, and provides a helpful forum for the exchange of activities and ideas on the work of state associations.

In summary, we would encourage anyone who is aware of a physician with a debilitating impairment to contact the KMA Headquarters Office in the best interests of the physician and his family, but most importantly, for the welfare of his patients.

David L. Stewart, M.D., Chairman

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed the Report of the Committee on Physicians' Health and its interest in improving KMA's efforts in this area in the State. We recommend that the House of Delegates consider directing that rehabilitated physicians be appointed as part of the membership of the Committee on Physicians' Health.

Reference Committee No. 3 recommends this report be accepted with this recommendation.

(The motion was seconded and carried.)

Resolution G

Joseph G. Whelan, Jr., M.D.

WHEREAS, Senate Bill 94, "the Kentucky Radiation Control Act of 1978," provides for regulations to issue licenses for x-ray machines and nuclear medicine facilities, to control the use and disposal of radioactive materials, and to conduct inspections and surveys of radiation facilities, and

WHEREAS, Administrative Radiation Regulation 902 KAR 100, effective September 5, 1975, provides for adequate regulation of radioactive materials and x-ray machines, and

WHEREAS, the nationally documented safety compliance rate of isotopes and x-ray machines in the state of Kentucky is better than the national average, and

WHEREAS, Senate Bill 94 provides for the Department for Human Resources to establish fees for these services, while the sole effect on medical use of x-ray equipment and radioactive materials will be to arbitrarily generate income for the administrative use of the Department for Human Resources, and

WHEREAS, the Kentucky Chapter of American College of Radiology opposes Senate Bill 94 as inflationary to the cost of medical care without a parallel increase in quality, now therefore be it

RESOLVED, that KMA support legislation to repeal or appropriately revise Senate Bill 94, and be it further

RESOLVED, that KMA undertake a study of the inflationary cost increases this law would cause, or be likely to cause, as well as be prepared to undertake studies of similar state statutes and regulations which have no beneficial effect on the quality of medical care but unnecessarily increase its cost.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed Resolution G, Kentucky Senate Bill 94 (1978), introduced by Joseph G. Whelan, Jr., M.D. We recommend that Resolution G be accepted with the deletion of the words, "repeal or" from the first "Resolved," making the first "Resolved" read:

"RESOLVED, that KMA support legislation to appropriately revise Senate Bill 94, and be it further."

We further recommend that the first line of the second "Resolved" be revised, making the last "Resolved" read as follows:

"RESOLVED, that KMA undertake to reasonably determine the inflationary cost increases this law would cause, or be likely to cause, as well as be prepared to undertake studies of similar state statutes and regulations which have no beneficial effect on the quality of medical care but unnecessarily increase its cost."

Reference Committee No. 3 recommends the adoption of Resolution G as amended.

(The motion was seconded and carried.)

Resolution H

Joseph G. Whelan, Jr., M.D.

WHEREAS, the Kentucky Department for Human Resources is enforcing certification regulations 902 KAR 105 for operators of x-ray equipment even though existing regulations provide for adequate safeguards and standards commensurate with the given procedure being performed, and

WHEREAS, current radiologic technology education programs are rigidly controlled by the American Medical Association, the American College of Radiology, the American Society of Radiologic Technologists, and the Joint Review Committee on Education in Radiologic Technology, and

WHEREAS, the nationally documented safety compliance rate for x-ray machines within the state of Kentucky is better than the national average, and

WHEREAS, the certification regulation, 902 KAR 105, provides for fees to be charged for certification of all radiation operators now, and

WHEREAS, the Kentucky Chapter of the American College of Radiology opposes the certification requirement of 902 KAR 105 as being unnecessary, duplicative and inflationary to the cost of medical care, now therefore be it

RESOLVED, that KMA support legislation to repeal or appropriately revise 902 KAR 105, and be it further

RESOLVED, that KMA undertake a study of the inflationary cost increases actually caused, or likely to be caused, by this regulation and similar state statutes and regulations relating to radiologic equipment.

Resolution N

Bullitt County Medical Society

WHEREAS, the Department for Human Resources continues to implement its regulation 902-KAR-105-040 regarding certification of operators of radiologic equipment, and

WHEREAS, the KMA House of Delegates at its September, 1977 meeting voted to pursue all reasonable efforts to amend or delete this regulation through appropriate legislative, administrative or legal channels, now therefore be it

RESOLVED, that the Kentucky Medical Association reaffirm its position.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 considered Resolution H,

Kentucky Administrative Regulation 902 KAR 105, introduced by Joseph G. Whelan, Jr., M.D., and Resolution N, Kentucky Administrative Regulation 902 KAR 105, introduced by the Bullitt County Medical Society, jointly since they both deal with Regulation 902 KAR 105.

Reference Committee No. 3 recommends that Resolution H and Resolution N both be adopted.

(The motion was seconded and carried.)

Resolution K

Floyd County Medical Society

WHEREAS, the Certificate of Need and Licensure Act for Health Services (KRS 216.405) is law, and

WHEREAS, this Act created a Board (KRS 216.405 (2)) whose authorization in the form of a Certificate of Need is required before a health service may be initiated, expanded, or modified, and

WHEREAS, private offices of physicians are to be excluded from KRS 216.405, and

WHEREAS, a state Attorney General's opinion that the Certificate of Need and Licensure Board may require that physicians who see patients on a referral basis apply for a Certificate of Need to expand their services and are not excluded from KRS 216.405, now therefore be it

RESOLVED, that KMA opposes the concept embodied in the Attorney General's opinion and its implementation as contrary to the exclusion of physicians' offices from Certificate of Need provisions in the statute.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed Resolution K, Certificate of Need, introduced by the Floyd County Medical Society.

We recommend that Resolution K be adopted.

(The motion was seconded and carried.)

Resolution O

Tri-County Medical Society

WHEREAS, the House of Delegates has supported certification of physician assistants in the past, this certification should not restrict the ability of any physician to delegate tasks presently done under his supervision,

WHEREAS, the Physician's Assistant Bill submitted to the 1978 Legislature contained a "Duffy amendment," which would have severely restricted the use of assistants in ophthalmologists' offices, and

WHEREAS, this provision would have driven up the cost of eye care, made it less efficient, and further extended the waiting time for routine eye care, and

WHEREAS, this is exactly opposite to the intent of having physicians assistants, now therefore be it

RESOLVED, that KMA oppose any future physician assistant certification bill that would restrict the use of personnel to specific delegated tasks in any physician's office, and that inclusion of a "Duffy amendment," or similar restriction, be opposed.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed Resolution O, Certificate of Physician's Assistants, introduced by the Tri-County Medical Society.

Reference Committee No. 3 recommends that Resolution O be adopted.

(The motion was seconded and carried.)

Resolution T

Jefferson County Medical Society

WHEREAS, the Jefferson County Fiscal Court recently adopted an ordinance attempting to regulate abortion, and

WHEREAS, specific sections of this ordinance address themselves to regulating the medical judgment of a duly licensed physician in a manner that attempts to dictate the specific criteria and predetermine his medical judgment under severe legal penalty, and

WHEREAS, this local government ordinance is an effort to regulate whom the physician will treat as a patient and the manner in which the patient will be treated, and

WHEREAS, the KMA by this resolution does not wish to make a statement either for or against the abortion question or in any way address the moral, ethical, or religious questions surrounding this controversial subject, now therefore be it

RESOLVED, that the KMA House of Delegates direct the Board of Trustees and the KMA Legislative Committee to resist any legislative attempt to adopt laws or regulations interfering with the private practice of medicine, whether the attempt be by the Legislature of the state, city or the 120 county governments in Kentucky.

Recommendations, Reference Committee No. 3

Resolution T, Local Government Ordinance Regulating the Practice of Medicine, introduced by the Jefferson County Medical Society, was reviewed by Reference Committee No. 3.

We recommend that the fourth "Whereas" be deleted, and that the words, "in conjunction with the affected county medical society when appropriate," be added to the "Resolved," making the "Resolved" read as follows:

> "RESOLVED, that the KMA House of Delegates direct the Board of Trustees and the KMA Legislative Committee, in conjunction with the affected county medical society when appropriate, to resist any legislative attempt to adopt laws or regulations interfering with the private practice of medicine, whether the attempt be by the Legislature of the State, city or the 120 county governments in Kentucky."

Reference Committee No. 3 recommends that Resolution T be adopted as amended.

The motion was seconded from the floor. Walter D. Harris, Delegate from Fayette County, made a motion that Resolution T be further amended in the first Whereas by changing the word "abortion" to the phrase, "the practice of Medicine." The amendment was seconded, and Resolution T was adopted as amended by the Reference Committee and the House.

Resolution W

KMA Board of Trustees

WHEREAS, the 1977 House of Delegates concluded that the only answer to the professional liability insurance coverage problem in Kentucky would be the formation of a company solely owned and directed by Kentucky physicians, thereby controlling their own destiny; and

WHEREAS, the 1977 House of Delegates, in its wisdom, directed that the KMA Board of Trustees take all necessary steps to organize the Kentucky Medical Insurance Company (KMIC) to provide professional liability insurance to physicians; and

WHEREAS, the Board of Trustees, in accordance with that direction, has successfully incorporated this company effective July 31, 1978; and

WHEREAS, the Board of Trustees developed, through the Physicians' Insurance Company of Ohio (PICO), a plan whereby Kentucky physicians, beginning on June 1, 1978, could purchase policies through PICO that would be transferred to the Kentucky Medical Insurance Company upon its capitalization; and

WHEREAS, over 100 Kentucky physicians have applied for policies and have indicated their strong support for this concept; and

WHEREAS, this House of Delegates recognizes that the success of this company depends upon its leadership and support and enthusiasm of the membership, and believing that Kentucky physicians should control their own destiny and not be placed at the mercy and whims of others; therefore be it,

RESOLVED, that this 1978 House of Delegates overwhelmingly and enthusiastically endorses the Kentucky Medical Insurance Company. It further urges all physicians present at the 1978 Annual Meeting to support actively the Kentucky Medical Insurance Company and, upon their return home, urge their fellow physicians also to support the KMIC.

Recommendations, Reference Committee No. 3

Resolution W, Kentucky Medical Insurance Company, introduced by the KMA Board of Trustees, was reviewed by Reference Committee No. 3.

We recommend that Resolution W be adopted.

(The motion was seconded and carried.)

Resolution X

Board of Trustees

WHEREAS, National Health Insurance continues to be a subject of intense Congressional concern that loses and gains attention relative to economic conditions, but remains a focal issue, and

WHEREAS, AMA policy on National Health Insurance was established in 1970 to protect and safeguard the interests of the private practitioner, and

WHEREAS, an AMA sponsored proposal is an effective tactical vehicle to give organized medicine a credible position in Congressional discussions and provides the best opportunity to influence various NHI alternatives, and

WHEREAS, NHI proposals will reappear in the 96th Congress and it is imperative for the AMA to continue to be a participant in these discussions with an influential voice, now therefore be it

RESOLVED, that this House of Delegates support the AMA and its Board of Trustees in determining the best methods to influence NHI as events develop, and be it further

RESOLVED, that any immediate concerns that arise related to AMA's position on NHI be transmitted to the AMA Board of Trustees through its President-Elect, Hoyt D. Gardner, M.D., in addition to using traditional channels.

Recommendations, Reference Committee No. 3

Reference Committee No. 3 reviewed Resolution X, AMA National Health Insurance Bill, introduced by the KMA Board of Trustees.

It is the recommendation of Reference Committee No. 3 that Resolution X be adopted. (The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 3 as a whole, as amended. (The motion was seconded and carried.)

Mr. Speaker, I wish to thank the members of this Reference Committee, Doctors Carl B. Caplinger, Millard C. Loy, Edwin J. Nighbert and O. M. Patrick, and Mrs. Doris Crume for her assistance in preparing our report.

REFERENCE COMMITTEE NO. 3
Charles C. Smith, Jr., M.D., Louisville, Chairman
Carl B. Caplinger, M.D., Hopkinsville
Millard C. Loy, M.D., Columbia
Edwin J. Nighbert, M.D., Lexington
O. M. Patrick, M.D., Frankfort

Following a short break, Wally O. Montgomery, M.D., Paducah, took the podium as Chairman of the KEMPAC Board of Directors to present the annual KEMPAC Board report which follows:

Mr. Speaker, fellow delegates and guests,

As chairman of the KEMPAC Board of Directors, I thank you for giving me this opportunity to report on KEMPAC activities this past year.

Last year, KEMPAC contributed in excess of $15,500 to candidates through physician candidate support committees for candidates in state races. This was actually a small amount of money contributed in comparison to other organized political action committees.

This year, KEMPAC is working with candidate support committees in support of candidates for the U. S. House and U. S. Senate. Twenty-thousand dollars have been contributed from KEMPAC through candidate support committees and AMPAC has contributed at least this much and perhaps a little more. This is what I want to speak to you about.

As most of you know, when KEMPAC was organized in 1962, it was organized to help select candidates for the U. S. HOUSE and SENATE only. After much thought, it was believed that with so many of the legislators on the national level coming up through the ranks, KEMPAC should get involved in state races. So in 1967,

KEMPAC, through physician support committees, started contributing to candidates for the Kentucky General Assembly.

Over the years, we have done many things right and we have done some things wrong. We have given support to losing candidates. We have given support to a strong candidate and also to his oppontent, often with disastrous results. We have given too little and we have given too late.

As a board, we are committed to looking even closer to voting records at the state and national levels and to giving more substantial support to key legislative races.

We must watch out for 1980. The following legislation could become effective with the 1980 Kentucky General Assembly:

(1) Use of therapeutic drugs by optometrists.

(2) Hospital admission privileges for chiropractors and podiatrists.

(3) State rate review for hospitals which shall include fees of physicians, cardiologists, pathologists and radiologists.

(4) Right of nurses to use prescription drugs and to practice independently.

Hopefully, we can defeat such legislation if it does arise in 1980. However, if physicians do not begin to realize the stark realities of the political world and how closely intertwined we are to those folks in Washington and Frankfort, then many of you are in for a rude awakening. Many physicians forget that government grants the physician the right to practice medicine and government can take away the right, as they did in Frankfort in 1978 (optometry and chiropractic bills).

At this time, by your active support of the right candidate for the Kentucky General Assembly next year you can do something to change the course of events. Through local physician candidate support committees, you can support the right candidate for office and we invite you to solicit support from KEMPAC for these candidates. However, for KEMPAC to have enough funds for effective support, you must work diligently to assure a greater percentage of Kentucky physicians belonging to KEMPAC.

With 20% of KMA's total membership belonging to KEMPAC, you can see who is really carrying the ball for all the physicians in Kentucky. Since you have been billed for KEMPAC and solicited by Board members, you know that there are several categories that can be selected for membership; however, we recommend Sustaining Membership, which is $100. If you have already paid Active Membership, you would only have to pay an additional $75 to be entitled to Sustaining Membership in KEMPAC and AMPAC. The Active Family membership is $50. You might ask, "What are the benefits for sustaining memberships?" The only additional benefit you get it self satisfaction that you have done more to preserve our right to practice medicine without government intervention.

Are you aware that only 35% of you delegates seated in this room are members of KEMPAC? There is a table set up at the rear and several of us will be there to accept your membership. We must stress that KEMPAC cannot accept corporate checks. State and federal laws prohibit this. If your practice is incorporated you must write your check on your personal account.

In 1977, as in past years, the KMA House of Delegate reaffirmed its belief in the objectives of KEMPAC and AMPAC and recommended 100% participation by doctors and their spouses. It further recommended a vote of endorsement and encouragement of the KEMPAC organization to continue its worthwhile political efforts on behalf of our free enterprise system and the freedom of the art and science of medicine.

I move that you reaffirm this endorsement and approve KEMPAC billing with the KMA dues billing. I wish to ask that you include your contribution when sending in your other dues. This is your organization and you must support it!

On behalf of the KEMPAC board, I want to thank the KMA Board of Trustees, you delegates, the Auxiliary to KMA and staff for your help and support.

Following Doctor Montgomery's presentation, a motion was made, seconded, and carried to accept the KEMPAC Report.

REFERENCE COMMITTEE NO. 4

James A. Baumgarten, M.D., Owensboro
Chairman

Reference Committee No. 4 considered the following reports and resolutions:

12. Report of the President, Kentucky Blue Cross and Blue Shield

20. Report of the Advisory Committee to Blue Cross and Blue Shield

24. Report of the Claims and Utilization Review Committee

33. Report of the Commission on Health Care Costs

40. Report of the Advisory Committee to KPRO

Resolution A—Voluntary Effort (KMA Board of Trustees)

Resolution L—Blue Cross and Blue Shield Assignments (Campbell-Kenton Medical Society)

Resolution Q—Insurance Procedures and Primary Care Physicians (Pulaski County Medical Society)

Report of the Kentucky Blue Cross and Blue Shield

I am pleased to provide a status report to the Kentucky Medical Association House of Delegates regarding Blue Cross and Blue Shield of Kentucky. This report will provide information on our enrollment, benefit payments, new products, changes in utilization and some concerns we face for the future.

Blue Cross and Blue Shield of Kentucky continues steady growth. As of June 30, 1978, there were 1,537,-937 Kentuckians with Blue Cross and Blue Shield coverage. This represents over 45% of the population of the Commonwealth. Of that 1.5 million members with basic benefits, we are pleased to advise that approximately one million of our members are enrolled in a major medical type coverage as a supplement to their basic Blue Cross and Blue Shield. Major Medical, among other benefits, includes coverage for out-of-hospital services, home and office services and prescription drugs.

In 1977, Blue Cross and Blue Shield of Kentucky paid $415,141,390 for provider and professional services. This represents an increase of 10.8% over 1976 and includes not only regular business, but also government contracts administered as well.

Thirty percent of our members are covered by the Usual, Customary and Reasonable Program. The Usual, Customary and Reasonable Program is designed to pay covered surgical and medical charges in full. Enrollment in the program is growing and is still in demand in the marketplace. The success of this program depends on the continued cooperation and participation of the physicians in Kentucky.

Participation in this program increased during 1977 by an additional 364 physicians that signed agreements to participate. Of the 3,550 eligible physicians, 2,875 are participating in this program, which represents 80.9% of the total.

Continuous effort is being directed to upgrading the level of benefits carried by our members. Currently, we are finalizing a new Blue Shield indemnity schedule that will provide increased payments for surgical procedures and much improved payments for inhospital medical services. A new high option Medicare Supplement has been finalized and will be offered for an effective date of January 1, 1979. Key features for the high option Medicare Supplement will be prescription drug benefits and catastrophic coverage up to $250,000.

One of the major issues facing the health care industry is the rise in costs. Actions by physicians, hospitals, government, carriers and others are being directed toward containing the rate of increase in health care costs. Some industries who are major purchasers of health care benefits are including programs to help hold down health care costs as a part of their contracts and they are monitoring the results of their carriers.

The cost of services and the utilization of services are issues to which the staff of Blue Cross and Blue Shield has given a great deal of attention. While the cost of services has continued to increase, we have been experiencing a decrease in the utilization of services by our members. During 1977, there was a decline in the length of hospital stays from 5.91 days to 5.80 days and a decline in the utilization of hospital days from 813 per 1,000 members to 766 days per 1,000 members.

These positive changes reflect the efforts of physicians, hospital administration and Blue Cross and Blue Shield members to properly utilize health care services. The changes in utilization have made it possible for us to provide a credit to our members in the calculating of their dues resulting in lower dues for Blue Cross and Blue Shield benefit programs than normally would have occurred.

The staff at Blue Cross and Blue Shield has initiated and implemented several voluntary programs directed toward the health care cost issue. We have on file with the Department of Insurance a 17-point program for cost containment, which has resulted in considerable savings in benefits and administrative costs, not only to our members, but also to the general public.

As a part of the National Voluntary Effort, we are participating with the Kentucky Medical Association and the Kentucky Hospital Association in the Kentucky Voluntary Cost Containment Effort. These programs, both locally and nationally, show evidence of achieving their objective of slowing the rate of escalation in health care costs.

By relating the cost of health care to Blue Cross and Blue Shield payment for covered benefits, we have tried to increase the public's level of awareness of its individual responsibility for good health. We consider health education a major key to holding costs down. Our members and the public must assume some responsibility for their own health. Employers are becoming more aggressive in health education. We are involved in several health awareness related activities. Our advertising approach encourages individuals to develop the proper eating habits, to exercise and to adopt a healthy lifestyle.

This approach is enforced through the development of publications for providers and members and groups. Recently we have distributed over 100,000 copies of the health education booklet, "Take Care of Yourself," purchased by employers for employees.

There are many positive activities occurring in the health care field. However, an item of major concern involves the number of hospital-based physicians who are no longer combining their professional fee with the hospital bill. Some physicians are voluntarily removing themselves from combined billing arrangements, and we are advised that several hospital-based physicians have been asked by the hospitals to terminate their contractual arrangements. The splitting off of these arrangements is increasing the cost of services. Our staff has been meeting with officials of the Kentucky Medical Association and the Kentucky Hospital Association, the hospitals and medical associations, as well as our national associations to seek meaningful guidelines in dealing with split-billing arrangements.

A special ad hoc committee appointed by the Kentucky Medical Association Board of Trustees developed and recommended guidelines for split-billing arrangements. These guidelines have been approved by the KMA Board of Trustees. On a national level, the subject of hospital-based split arrangements is receiving attention. The staffs of the American Medical Association, the American Hospital Association, and the Blue Cross and Blue Shield Association have been requested to study the matter and report to the steering committee for the National Voluntary Cost Effort.

As we look to the future the pressure for cost containment will continue from both the public and private sources. The National Health Insurance debate will be renewed with the administration pursuing a National Health Insurance program that will be phased in over a number of years. In a short time frame, the administration will stress perfecting amendments to current legislation with emphasis on cost control and will address the problem of The "near poor" without adequate access to care. Even though opposed by labor, passage of a catastrophic program by Congress is a real possibility.

The future of Blue Cross and Blue Shield of Kentucky is very promising. The voluntary pre-payment system is strong, it is vital, and it continues to grow. The coming years undoubtedly hold many opportunities and many challenges. Our philosophy continues to be that our members and the public are better served through a close

working relationship with the physicians. Working together as a team, we can take advantage of the opportunities as we face the challenges of the future. As always, our staff is available to work with the medical profession.

Donald W. Giffen, President

Recommendations, Reference Committee No. 4

The Report of the President, Kentucky Blue Cross and Blue Shield was reviewed by the Reference Committee. Again, the Report was noted to contain factual information concerning the activities of Blue Cross and Blue Shield in the past year showing growth and introduction of new programs. We commend the President, Donald W. Giffen, for his excellent and informative report. Reference Committee Number 4 recommends that this Report be filed.

(The motion was seconded and carried.)

Report of the Advisory Committee to Blue Cross and Blue Shield

The KMA Advisory Committee to Blue Cross and Blue Shield met at the KMA Headquarters on April 20, 1978.

The first order of business was to review the purpose of the Committee which is to "monitor the operation of Kentucky Blue Cross and Blue Shield with the objective of striving to furnish for the public the most advantageous coverage possible for the dues paid, avoiding abuses of Blue Cross and Blue Shield to include studying and correcting trends before they develop into abuses and continuing to keep Kentucky physicians informed, interested and with a voice in the operation of Blue Cross and Blue Shield."

In addition to Mr. Doug Sutherland, Senior Vice President; Mr. Alan Leichhardt, Director of Provider and Professional Relations; and Mr. Fred Compton, Assistant Director of Provider and Professional Relations, we were pleased to have two members of the Medical Services Division of Blue Cross and Blue Shield of Kentucky, B. Frank Radmacher, M.D. and Parnell Rollings, M.D. with us.

Staff Reports

Staff reported that 1977 membership enrollment reached 1,535,563 at year's end.

The Professional Relations staff made over 8,500 contacts with physicians' offices during 1977. In addition, workshops were designed to help office assistants interpret I.D. cards, prepare claims properly and exchange information about the Plan's policies and procedures.

Administratively, it costs as much to reject a Blue Shield claim as it does to pay one. Blue Cross and Blue Shield staff has identified services having the highest volume of rejections and is continuing its concentrated effort to educate physicians' office personnel on current claims filing procedures. As a result of these efforts to reduce the number of claims filed for non-covered services, a reduction in the number of rejections was noted for 1977 over 1976. This reduction is significant considering that there was a 4.5% increase in Blue Shield claims filed during the same period.

To speed claims processing, medical assistants should include procedure codes along with nomenclature when filing Blue Shield claims.

Effective May 1, 1978, all physicians in Kentucky were provided with preprinted claim forms with the physician's name, address and collecting code. This additional service will hopefully reduce some of the administrative work for medical assistants.

Blue Shield staff reported that during 1977 the Claims Division was reorganized into: The Blue Cross and Blue Shield Division, which processed basic claims, and the Special Benefits Claims Division, which processes Major Medical, Drug, Delta Dental, Extended Benefits and Medicare Supplement Claims.

The volume of all claims processed by Blue Cross and Blue Shield increased in 1977. Although Blue Cross Claims decreased, both Blue Shield, Major Medical and other supplemental programs recorded increases. In 1977, the Usual, Customary and Reasonable Program paid over 474,000 services amount to over $24.9 million. The total dollar amount paid to physicians for all services rendered in Kentucky in 1977 exceeded $52 million.

Over 10,800 claims were processed in accordance with the Coordination of Benefits provision, amounting to a savings in claims payments of $4.8 million for Blue Cross and Blue Shield claims.

USUAL, CUSTOMARY AND REASONABLE

Over 432,000 Kentuckians are now covered by Usual, Customary and Reasonable contracts and 81% of the eligible physicians in Kentucky have signed agreements to participate.

At your 1977 House of Delegates meeting, Resolution K was introduced by the Campbell-Kenton Medical Society, requesting that the Kentucky Medical Association "use every method at its disposal to see that Kentucky Blue Shield develops a satisfactory method of fee assignment for all Blue Shield services by participating and nonparticipating physicians which would not discriminate against a small segment of their insured."

This resolution was adopted and following the meeting, Resolution K was forwarded by the KMA Board of Trustees to Blue Cross and Blue Shield of Kentucky for a response and to this committee for study.

The two issues discussed by the passage of this resolution are, first, for Blue Shield of Kentucky to develop a method of accepting assignment of benefits from nonparticipating physicians and, second, the statement that discrimination should not exist against patients whose physicians are not participating in the Blue Shield Usual, Customary and Reasonable program. With these issues in mind, your Committee reviewed the operation of the Usual, Customary and Reasonable mechanism in considerable detail.

The first issue discussed was assignment of benefits as it relates to the Usual, Customary and Reasonable program. Blue Shield staff reported that an assignment of benefits attached to a Blue Shield claim by nonparticipating physicians was originally accepted in the early development of the program. Physicians were skeptical about the operation of the Usual, Customary and Reasonable concept; and therefore, Blue Shield agreed to honor assignments in an effort to demonstrate the program operation.

In accepting assignments, certain administrative difficulties arose for Blue Shield. One involved the additional handling required for claims submitted by nonparticipating physicians with an assignment of benefits attached. Special handling created additional opportunities for error since the claims had to be handled manually. In addition, some participating physicians objected to our accepting assignments because nonparticipating physicians were not committed to the peer review mechanism, yet payments were directed to them. Participating physicians were making a commitment to peer review.

The certificates of membership for those members covered under the Usual, Customary and Reasonable program state that payment will be made directly to the participating physician and payment for services rendered by the nonparticipating physician will be made using the same guidelines; however, payment will be made to the Blue Shield member. Likewise, your 1969 House of Delegates, in reaffirming its support of the Usual, Customary and Reasonable concept, recognized the right of the individual physician to participate or not to participate in the Usual, Customary and Reasonable program. It was stated that physicians who elect to participate be reimbursed directly for their services. Physicians who elect not to participate will have their claims administered using the same guidelines as the participating physician; however, payment will be made to the member.

Nonparticipating physicians have expressed to members of this Committee and to Blue Shield their preference of dealing directly with their patient as a reason to not participate in the Usual, Customary and Reasonable program.

The second issue in this resolution questions whether discrimination exists in the administration in the Usual, Customary and Reasonable program, if payment is made to the patient rather than the physician. Your Committee has determined that in its opinion no discrimination exists for the following reasons:

1. The same guidelines are used to determine an allowance for services rendered by nonparticipating physicians as well as participating physicians.

2. Participating physicians agree to either voluntarily reconsider fees that exceed Usual, Customary and Reasonable guidelines or agree to accept a peer review committee recommendation as payment in full.

3. Nonparticipating physicians do not have to voluntarily reconsider their fees, nor are they bound to accept the recommendation of a peer review committee. Therefore, the nonparticipating physician can bill the patient for the difference between Blue Shield's allowance and his fee, whereas a participating physician cannot.

4. The purchaser of the Usual, Customary and Reasonable certificate must have some assurance of the cost involved; therefore, the Usual, Customary and Reasonable program operates as a cost containment mechanism. Likewise, the carrier who markets a Usual, Customary and Reasonable certificate to a group needs some assurance that benefits can be delivered based on the rate for Usual, Customary and Reasonable benefits.

In further discussing the Usual, Customary and Reasonable program, your Committee recognized that participation was designed to be voluntary on the part of the practicing physician. It was reported during 1977, out of 470,000 services on members covered under the Usual, Customary and Reasonable program, only 64 cases were sent to peer review. This test of performance demonstrates the Usual, Customary and Reasonable program is working.

It is your Committee's recommendation, therefore, that Blue Cross and Blue Shield of Kentucky continue the current method of administration for the Usual, Customary and Reasonable program.

HEALTH COSTS AWARENESS

With the encouragement of the House of Delegates of the Kentucky Medical Association, Blue Cross and Blue Shield of Kentucky developed a method of advising physicians of the cost of services they order for Blue Cross patients.

In March of 1977, all Kentucky physicians received a mailing indicating how their patients compare with those of their peers in the areas of length of stay, cost per case, and ordering of lab, x-ray and medication. In addition, staff personally contacted over 400 physicians to discuss their physician summary. As a result of these contacts, many physicians requested special followup studies on their practice patterns.

Last year, we reported that Blue Cross and Blue Shield staff had identified 20 hospitals whose utilization of inhalation therapy services had risen dramatically following the execution of a contract with private firms marketing these services in our state. Following contact with hospital administration, the private firms themselves and, where necessary, hospital medical staffs, a significant reduction in utilization occurred.

The 1977 report included information on the implementation of certain pilot projects designed to attempt to contain the rise in health care costs.

The first project is an experiment whereby hemophiliac patients can receive take-home drugs following hospitalization in order to reduce the incidence of use of the emergency room. This experiment will run for two years at four hospitals. During the first six months of operation, it is estimated that over $14,000 was saved. In addition, the service rendered to the patient by eliminating the time and expense of returning to the emergency room for the drugs should be of benefit to the patients.

The other experimental program involves the establishment of concurrent review activities for Blue Cross inpatients in two pilot hospitals. These activities began in January of this year. The purpose of the concurrent experiment is to reduce unnecessary lengths of stay, reduce the incidence of unnecessary admissions, eliminate retroactive denials for unnecessary lengths of stay and eliminate retroactive denials of diagnostic admissions.

Another item of interest to the committee involves an increasing number of hospital-based physicians who are no longer combining their professional bill with the hospital's bill. Staff reports that additional requests for split-off arrangements are occurring frequently and that meetings are being held with specialty group leaders and the leadership of the Kentucky Medical Association, the Kentucky Hospital Association and the Plan's National Associations. This is of major concern to Blue Cross and Blue Shield inasmuch as it requires the filing of hundreds of thousands of additional claims which adds substantially to the administrative cost both to the physician and the patient. This increases the cost of health care without any increase in quality or economic benefit.

MEDICAL SERVICES DIVISION REPORT

The Medical Services Division reported on the update of the Medical Review Committee as discussed at our 1977 meeting.

The purpose of this committee is to expedite the adjudication of claims relating to the necessity of admission and length of stay. This committee of consultants will not circumvent the peer review mechanism but rather it will provide additional professional review to assist Plan physicians. Blue Cross and Blue Shield will continue to utilize the various trustee districts and local hospital utilization review committees as they have in the past on appealed claims. The Medical Review Committee will not review Blue Shield claims involving fees. The Medical Review Committee as proposed would consist of a representative segment of physician specialties located throughout Kentucky who would voluntarily serve for a three-year period. It is anticipated that this committee will be operational by the end of this calendar year.

Your Committee was asked to review an article that would appear in the Kentucky Medical Association *Journal* addressing two issues. The first problem concerns patients who are admitted to the hospital for consultation purposes only. Often, that patient could have been referred to the consulting physician rather than being admitted. Many times this represents unnecessary hospitalization and normally, such claims are not paid under existing Blue Cross and Blue Shield contracts.

The second issue refers to a referring physician who contacts a specialist for consultation and requests that the patient be admitted for a consultation and evaluation. Occasionally, the consultant hospitalizes the patient only to find out that the necessary examinations could have been performed on an out-patient basis.

Most Blue Cross and Blue Shield contracts will not pay for hospital care unless definitive treatment is called for. The Plan believes that there can be a cost savings without reducing the quality of care if these consultations are performed prior to hospitalization. This Committee agrees to submit this information for publication in the Kentucky Medical Association *Journal*.

The Medical Services staff reported that while evaluating Major Medical claims, they occasionally find overutilization of drugs by patients. After notifying the attending physician, it has resulted, in many cases, in a dramatic reduction in the use of drugs. In addition, we have also observed certain patients' use of the emergency room for injection of narcotics. Medical Services staff contacts the attending physician and usually the response results in a reduction in utilization and occasionally causes the patient to change physicians.

New Activities

Staff reported the implementation of a Hearing and Vision Program for employees and dependents covered under the United Auto Workers contract. The benefit was a result of negotiations between Blue Cross and Blue Shield of Michigan and the United Auto Workers during the last contract talks. When the Michigan Plan was asked to provide this benefit, there were no provisions in the proposal to make different allowances for covered services depending upon whether a physician was participating or nonparticipating in this specific program. However, the final benefit package approved by the United Auto Workers included payment differentials as a part of this benefit. The payment differentials for this account left Kentucky Blue Cross and Blue Shield the alternative of not participating with the Motors account for the Hearing and Vision Program, thereby jeopardizing the entire Motors contract. In the case of the Motors program for hearing and vision benefits **only,** a reduced allowance is made to the nonparticipating physician. It was reported to this Committee that any payment differentials are for benefits in the Hearing and Vision Program. There are no administrative changes in payments for services covered under the Usual, Customary and Reasonable Program for medical and surgical benefits.

Blue Cross and Blue Shield of Kentucky has a corporate policy which prohibits payment differentials to participating and nonparticipating physicians. Staff also reported the planned development of a Hearing and Vision Program for eligible groups underwritten by Blue Cross and Blue Shield of Kentucky, which makes the same allowance to both participating physicians directly and to our members who receive services from nonparticipating physicians.

Esten S. Kimbel, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to Blue Cross and Blue Shield was reviewed in its entirety by Reference Committee Number 4. Considerable discussion was held concerning this lengthy and informative Report and the majority of the Reference Committee recommends the acceptance of the Report of the Advisory Committee with the exception of the section dealing with the Usual, Customary and Reasonable Program, beginning on Page 20.2 and ending on Page 20.5. The majority of the Reference Committee agrees with the Board of Trustees that this section of the Report dealing with UCR be rejected for reasons which will be discussed later in this Report. A minority report will be filed at the end of this Reference Committee Report.

We recommend that the section on Page 20.9, dealing with "New Activities" be deleted from this Report since this has been resolved because of information reported to the Committee by Doctor Gardner.

The motion was seconded from the floor. A subsidiary motion was entertained that consideration of the Report of the Advisory Committee to Blue Cross and Blue Shield be deferred until action had been taken on Resolution L. The motion was seconded and carried.

Following consideration of Resolution L by the House, the Report of the Advisory Committee to Blue Cross and Blue Shield was then before the House.

Thomas L. Heavern, Jr., M.D., Delegate from Campbell County, was recognized and offered a substitute motion to the Reference Committee's recommendation by proposing that the last three lines on page 20.5 be deleted and the remainder of the report be filed. The last three lines on page 20.5 read as follows:

"It is your Committee's recommendation, therefore, that Blue Cross and Blue Shield of Kentucky continue the current method of administration for the Usual, Customary and Reasonable Program."

On a call for the vote, the substitute motion was passed.

Report of the Claims and Utilization Review Committee

The volume of claims reviewed by the state Committee has declined this year over previous years. This is due to fewer carrier referrals. Hopefully, fewer cases are being referred because of earlier efforts by the peer review system, and because physicians are more familiar with peer review and carrier operations.

The bulk of the Committee's work was devoted to review of utilization cases and some precedent matters. The two most often encountered questions in utilization cases involve necessity of admission and questions on the lengths of stay and services rendered while hospitalized. The Committee would like to suggest to all individual members that close attention be paid to each patient that is hospitalized to insure that the confinement is terminated as soon as medically possible. As physicians, we should also carefully consider the need for hospitalization in questionable situations.

The Committee would also recommend to the membership that complete and concise records are vital for appropriate care. In all too many instances, cases we have reviewed would not have even come before us had the records been more complete.

A new procedure approved by the Board of Trustees this year was the use of conference calls by district committees when only a few claims needed to be reviewed. This was started to assist district committees and allow the convenience of conducting a meeting when the committee members reside in different areas. The intent was to help make review more timely. A portion of this effort requires that the attending physician somehow be included in the discussion of the case. Apparently, not many committees have used conference calls, but those that have, have found them helpful.

The Committee was asked by the Board of Trustees to consider any cases that might be referred under Project Integrity from the Attorney General's Office. Project Integrity is a joint state/federal audit procedure that attempts to identify the "top" 25 physicians in the state in terms of defrauding or abusing the Medicaid Program. Only two cases under Project Integrity were brought to the Committee with, as yet, unclear results. Traditionally, the Committee's obligation has been to make itself available to any carrier and physician wanting to use the review system. While the Committee's recommendations have not always been fully abided by on the part of carriers, this situation has been rare. The Committee feels it should remain available for Project Integrity reviews, but is concerned that the final outcome should be equitable to everyone concerned.

I would like to take this opportunity to thank all members of the state Committee, and special thanks to the Chairmen of the district peer review committees and their members, where most review activities take place.

Stuart Graves, Jr., M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Claims and Utilization Review Committee was reviewed and discussed by Reference Committee Number 4. We feel that this Committee is doing an excellent job and we appreciate their many hours of dedication to their duties. The Reference Committee recommends that this Report be filed.

(The motion was seconded and carried.)

Report of the Commission on Health Care Costs

In a recent national Gallup poll conducted for the AMA, the cost of health care was cited as the major issue of concern to both physicians and consumers. Expenditures on health care over the past ten years have grown at an average annual rate of 11%, a rate which is higher than that of the rest of the economy. After years of consumer demand for unlimited care, government promotion of growth in the production of providers and facilities, and physicians providing service based solely on quality, society is now calling to question the cost of delivering that service.

To examine the issue of health costs, the KMA Commission on Health Care Costs was established by the Board of Trustees in the Spring of 1977. The Commission is composed of 38 members representing providers, consumers, commerce and industry leaders, labor, third parties, government and the communications media. In the brief period the Commission has been in existence, the members have given freely of their time, energy, talent, and most importantly, their opinions in addressing the extremely complex issue of health care costs.

Most of the issues initially discussed by our Commission were also addressed by the National Commission, appointed by the AMA.

After our report to the Board of Trustees last year, that Board suggested that we review the National Commission Report released in December and evaluate its recommendations as they might apply to Kentucky. (A recommendation made last year by this Commission that the Governor appoint a group to survey health care costs, was felt by the KMA Board to be inappropriate.)

The National Commission Report contains 48 recommendations which call for a substantial restructuring of the incentives available to consumers and providers of health care. Many of these recommendations are applicable to Kentucky. Some can be implemented immediately; some are long term, while others are in effect now.

Rather than comment on each of the Commission's 48 recommendations, this report will attempt to address containment of health costs in light of the KMA Commission's discussions, but will include background and excerpts from the National Commission Report.

It is important to note that certain characteristics inherent in the health care delivery system make it unique in a discussion of costs, in that it differs from an economist's model of an ideal market. Among the most important differences are the structure of health insurance; the lack of consumer knowledge regarding the cost, efficacy, or necessity of specific medical procedures; and the potential ability of the provider to affect demand.

The problem of cost is a product of our society. No one group of individuals can be blamed for rising costs but there is not one group who hasn't contributed to the problem. Thus, the solutions, if in fact there are any, are complex and necessarily far-reaching.

There are two approaches to dealing with health costs that are becoming the most widely used: 1) Increased regulation by government to exert widespread control over costs, and 2) strengthening price consciousness of providers and consumers through the private sector. All regulation is not necessarily bad and all efforts to increase price consciousness will not be completely effective.

Strengthening price consciousness has the benefit of relying on traditional free enterprise market mechanisms, which can lead to cost-effective production of output while permitting the consumer to play a key role in the determination of goods and services produced. However, total reliance on price as a mechanism for gaining access to care can have an adverse impact on the poor. In addition, for a market to function well, the consumer must be informed about prices, qualities and efficacy of the alternatives available.

Regulation can serve to avoid needless duplication of equipment, and gives some degree of protection to the public.

However, regulation has not always proven effective in reducing prices in other industries. Such regulation may result in higher prices, less competition and reduced innovation. A fundamental problem with the regulatory approach, in terms of health care delivery (Certificate of Need, regional budget and revenue limits), is that the regulator cannot possibly take the wide variety of consumer preferences into account when formulating policy. What often results is a bargained compromise which pleases no one.

A strategy combining elements of price consciousness and some regulation would remove many of the problems inherent in strict regulation. An important difference is that total expenditures would be determined on the basis of individual decisions rather than by administrative fiat that would restrict individual choice. The greatest possible number of decisions about health care must remain with the individual patient and provider as they are the best judge of what is required in each case.

While the management of health care institutions should reflect an awareness of costs, cost containment is not the only goal. There will usually be a cost increase associated with progress. The objective should not be interpreted as keeping resources devoted to health from growing, but rather to give those whose decisions affect health resources the desire to be cognizant of costs and to deal appropriately with those which are improper.

Most people in Kentucky today have third party insurance coverage. The philosophy of insurance is to provide monetary protection in time of need. Because of the reliance on third parties to pay the health care bill, most consumers do not understand the effect of utilization on cost and there is little incentive for them to become aware of that relationship.

To strengthen price consciousness in the presence of insurance, the **Commission recommends:**

1. Coverages offered should be clearly written to reflect what is being purchased and at what cost. Alternative coverage plans (group and individual) should be offered in the marketplace and be available to all consumers.

2. All insurance policies should encourage consumer cost consciousness. While no one type of coverage plan was felt to be outstanding in encouraging cost consciousness, incentives discussed included premium rebates for non-utilization; greater usage of copayment or deductible plans; coordination of benefits; the limiting of first dollar coverage and consumer education programs.

Price consciousness can also be increased by offering the consumer a choice among competing health delivery arrangements. The **Commission recommends:**

3. KMA reaffirm its endorsement of the pluralistic approach to health care delivery. In addition, an effort to develop a clear demonstration of the cost effectiveness or lack thereof of the different types of delivery systems available should be undertaken, the results of which could be made available to the public.

In order for the consumer to exercise informed choice, conditioned by price consciousness, he must be able to obtain information on alternative providers and health plans. **We recommend:**

4. Consideration be given to voluntarily developing directories which would provide information on physicians' services which might include prices of well-defined procedures, length of time to obtain an appointment, willingness to accept new patients, specialty certification and institutional affiliation. Similarly, hospital directories could be developed outlining the cost of services and daily rates.

Consumers should be encouraged and assisted to become more active and knowledgeable participants in making health care utilization decisions. The **Commission recommends:**

5. Development of health and patient education programs drawing on the expertise of providers, third parties and the communications media, and implemented through existing advertising and public information mechanisms.

6. Emphasis of self-help programs directed at well and worried-well individuals to enable them to make the initial decision as to whether or not provider care is necessary as opposed to self-care, bed rest or the use of non-prescription drugs or first aid.

Since health costs are a problem common to all of society, other organizations should be asked and encouraged to participate in these educational programs.

Cost containment in health care may also be accomplished through the reduction of the need for a service through the development of more healthful lifestyles and the early detection of conditions which may permit lower cost therapy. The **Commission recommends:**

7. Educating and motivating consumers to adopt more healthful lifestyles.

8. Exploring methods of using public communications more effectively in health education efforts directed toward motivating consumers to adopt healthier lifestyles.

The providers of care must also become more price conscious. As purchasers of care for their patients, physicians must carefully weigh the benefits to be derived from a test or procedure before ordering it performed and must take steps to make cost effective utilization recommendations without sacrificing quality of care. The **Commission recommends:**

9. Providers, working at the local level, should develop mechanisms for sharing diagnostic findings for a given

patient to avoid duplication of expensive tests and procedures. Research should be undertaken to determine cost efficacy of other innovations such as pre-admission testing, transfer of patient records between hospitals, weekend surgery and elimination of mandatory hospital admission tests.

The Commission was pleased to learn that our medical schools have included graduate level courses on the economics of health care in their curricula and encourages their further development.

The Commission discussed the issue of second opinions prior to surgery and noted the concept is being explored in several areas. Studies have shown that second opinions do not always recommend surgery. However, since there is no evidence that proves that second opinions are more valid than first opinions, these results do not constitute sufficient evidence to conclude that there is excess surgery. The long-range effect of such programs have not yet been measured. Such measurement and general adaptability of these programs should be evaluated in terms of quality of care, cost effectiveness, the cost and quality of care rendered in place of surgery and the long-term medical implications for the patients who did not have surgery.

The topic of hospital based physicians was discussed, as was the recent trend for separate billing to the patient on the part by those physicians. The Commission felt that billing patterns should be the prerogative of the physician involved but **recommends:**

10. If these physicians split their billings from hospitals, the net result should not be an increase in the cost of care.

Since physicians are called on to make medical decisions on behalf of their patients, they may occasionally recommend care that others might consider inappropriate. The decision to prescribe such care may be influenced by patient preference and pressure or physician attitudes regarding current and acceptable medical practice. The **Commission recommends:**

11. The medical profession should examine those factors associated with medical practice that lead to inappropriate care and assume responsibility for informing providers and consumers of their existence and impact.

The Commission recognizes there are physicians who act in an unacceptable manner with patients and their insurors and that often the action of those few reflect badly on the entire profession. This minority not only does not deserve the protection of the profession, but should be censured. It was noted that Kentucky's Medical Licensure Legislation has been updated to give it broader authority in disciplinary measures.

In discussing the effectiveness of strengthening price consciousness versus rate regulation, it becomes apparent that each has significant benefits and genuine drawbacks. However, no market, especially one as complex as health care delivery, can operate entirely free of regulation.

Thus, there is a role for some form of regulation in several areas of health care delivery and many such regulations are already in place.

Some of the oldest and most clearly established regulations protect the consumer by providing information on the qualifications of those allowed to practice medicine (state licensure), the safety of drugs (Food and Drug Administration) and the financial security of insurance institutions (state insurance commissions).

Controls on the delivery of health care are now a fact of life. As government plays a greater part in paying the bill for health care, a greater number of these controls deal with costs.

In the absence of efforts to strengthen consumer and provider price consciousness, some form of regulation, such as controls on rates and revenues, are likely to become necessary to achieve cost containment. However, to embrace an untested and specific regulation of revenues could produce a health delivery system that neither patients nor providers would find satisfactory. Thus, a careful study of regulation, as it would apply to health care delivery, should be made before any widespread adoption occurs.

Presently, there is a Certificate of Need Law in Kentucky. The **Commission recommends:**

12. If Certificate of Need proves ultimately to be satisfactory as a cost containment technique for inpatient institutions, consideration should be given to the feasibility of reviewing and approving replaceable equipment outside of hospitals. Review of such equipment should occur when costs exceed $100,000 but should not cover the building of offices or clinics.

The Commission noted that several of the regulatory issues addressed by the National Commission are underway in Kentucky and we would recommend:

13. KMA should continue to monitor and actively participate in the processes of HSA, PSRO and other planning activities. The Commission feels there should be a reduction or elimination of unnecessary facilities and services. Underutilized facilities must be converted to meet other health care needs of the communities they serve.

While the National Commission Report opposed the use of capital expenditure limits as a reasonable cost containment measure, there was a feeling in the KMA Commission that capital expenditure limits on a statewide basis should be developed, based on reliable methodology and criteria to force priority setting in a public context. Careful scrutiny must be given to any proposal to limit capital expenditures, keeping in mind the difficulties inherent in establishing limits which would not be arbitrary and uneven in their application.

It is felt that highly leveraged financing schemes for construction of facilities should not be permitted as long as facility availability on a statewide basis exceeds demand or other construction financing does not exist.

The Commission does support voluntary hospital rate regulation by reviewing charges, capital acquisition and program expansions. The process, such as is currently being done in Kentucky, should be open to public scrutiny and should be financed by all third parties and purchasers of care. "Prospective reimbursement" seems to be an effective process and should be further evaluated as a cost containment measure.

Planning in Kentucky is established by law and exceeds most areas of the country in the quality of its results. The Commission believes that for planning to be truly effective, it must apply to government operated facilities, such as Veterans Administration hospitals, as well as those in the private sector. The **Commission recommends:**

14. Kentucky's Congressional Delegation and appropriate state officials be urged to discontinue the exclusion of state and federal facilities and services from planning guidelines which govern the private sector.

15. Third party carriers should reinforce the planning process by reimbursing only those which comply with accepted planning criteria and standards.

The Commission has noted that many programs promulgated to effect cost savings are of doubtful cost-effectiveness because of "overhead" costs. The **Commission recommends:**

16. If controls on revenues, capital acquisition or prices are expanded, attempts using carefully controlled experiments (e.g. introduction of regulation only in a given area) should be made to evaluate the effects.

Further, regulation whose rationale is cost containment should exempt organizations or areas where innovations are being tested for the purpose of cost containment or where strategies to increase price consciousness are being pursued successfully.

17. The cost of regulations of all kinds, both government and voluntary, have a significant impact on the total cost of care. Attention must be given to the simplification of the regulatory process and to consolidating and reducing the number of inspections, audits, surveys, reports and other mechanisms of enforcement.

Reduction or elimination of unnecessary facilities and services must occur. Underutilized facilities should be converted to meet other health care needs of the communities they serve. The **Commission recommends:**

18. Consideration should be given to providing financial assistance of the modification of inpatient hospital services to other health purposes. It is felt this may result in less cost in the long run than continued maintenance of underused acute care facilities.

19. Restraint should be exercised by health care providers to attempt to keep the rate of cost escalation more closely in line with increases in the cost of living. The Commission is aware of and supports the Voluntary Effort which is addressing hospital cost issues and the positive posture taken by the leadership of the AMA in calling for individual physicians to voluntarily restrain the rate of professional fee increases.

Decisions to utilize hospital facilities are made principally by physicians in consultation with their patients. The expansion of public and private health insurance has brought about a variety of review programs with the twin objectives of cost containment and quality control. The Commission feels such review mechanisms have an impact on cost from the standpoint of fees as well as utilization of hospital and ancillary services.

We feel consideration might also be given to a review of physician in-hospital practice profiles by the hospital medical staff.

The question of physician supply was discussed by the Commission. Research has shown that physicians, for many reasons, tend to locate in the urban centers of this country and not necessarily where their services are most needed. The **Commission recommends:**

20. Greater efforts be made to develop incentives to motivate physicians to locate in underserved areas.

21. Further emphasis and expansion of the Area Health Education System in Kentucky should be encouraged. This program places students in rural areas for a portion of their undergraduate clinical experience. The Commission noted the efforts of the Rural Kentucky Medical Scholarship Fund to help motivate physicians to locate in rural areas of Kentucky.

Increased specialization in non-primary specialties has the effect of discouraging physicians from locating in those underserved places that are likely to be some distance from centers of learning and related support facilities. Research has shown that family practitioners tend to respond differently than other physicians to various location forces. Thus, an increase in family practitioners might lead to a more equal distribution of physicians. The **Commission recommends:**

22. Kentucky should continue to emphasize the further development of family practice capacity by training more family practitioners. Consideration should be given to the modification of limitations on allied health professionals, particularly in primary care settings, as long as quality of care is assured.

A considerable amount of time and effort was put into the discussion of health costs by the members of this Commission. They served and traveled from all parts of the state, at their own expense, their only reward possibly being a part of an effort to influence a complex issue which affects all of us. I am most appreciative of the time and effort given so freely by them.

Walter I. Hume, Jr., M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Commission on Health Care Costs was reviewed by Reference Committee Number 4. The Reference Committee commends the Commission for its indepth study and recommendations arising from this Report. The Committee reviewed the Report in its entirety. Considerable discussion was heard concerning the entire Report. The Reference Committee realizes the complexity of the issues and recommends that the Report be referred to the Board of Trustees for further definitive study and action.

(The motion was seconded and carried.)

Report of the KMA Advisory Committee to KPRO

As of July, 1978 KPRO completed implementation of concurrent (admission and length-of-stay) review in all of the 109 acute care hospitals eligible for reimbursement under Medicare, Medicaid and Maternal and Child Health programs. Of these hospitals 78 are delegated and 31 are non-delegated. A very important by-product of this review is the mass of data with clinical relevance which has been collected by KPRO. Utilizing these data KPRO is now able to provide hospitals with a monthly "mini-audit." Each mini-audit focuses on a specific disease entity or topic of clinical interest and allows each medical staff to compare its hospital's performance with that of other hospitals of similar size and with all hospitals in the State as a whole. The specific items included in any mini-audit might be morbidity, mortality, incidence of medical complications, surgical complications, adverse reactions to therapy, etc. It is hoped that these mini-audits will be of general interest and, further, may serve as indicators for areas where medical care evaluation studies might be worthwhile.

Within the next month or so KPRO will begin implementation of review in the 200 long-term care facilities in the State. The mechanics of this review will be very similar to those used in acute care hospitals except that the interval between review will be greatly increased. Also, instead of using disease-specific criteria for admission and continued stay certification, the level-of-care required by the individual patient will serve as the justification for their treatment in a long-term care facility.

Also, within the next few months, KPRO will begin to review the utilization of ancillary services (i.e., x-ray, laboratory, respiratory therapy, pharmacy, etc.) in hospitals throughout the State. In those institutions which seem to demonstrate either over or under utilization of ancillary services, a medical care evaluation study of that service within the hospital will be requested in order either to justify the apparent unusual utilization pattern or to correct those situations where actual malutilization of services has occurred.

Finally, a word about confidentiality. As of this writing there is some question as to whether PSROs may have to divulge certain profiles or information identifiable to individual physicians. As of this time KPRO is not required to and will not divulge any information identifiable to a given practitioner. Should the Federal courts rule that such information must be made public and should there be no legislative relief from this decision, the KPRO Board has on more than one occasion reaffirmed its policy that it would dissolve the corporation and destroy the master code lists necessary for identifying physicians and hospitals within the computerized data file (thus rendering the data already collected totally unintelligible to anyone).

W. Neville Caudill, M.D., Chairman

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to KPRO was reviewed by Reference Committee Number 4. That Chairman, Doctor W. Neville Caudill, was present and asked that the third paragraph of the Report be deleted in its entirety. Again, the Reference Committee was assured by Doctor Caudill as to the confidentiality of their data. The Reference Committee recommends that this Report be filed with the deletion of Paragraph 3, as stated.

(The motion was seconded and carried.)

Resolution A

Board of Trustees

WHEREAS, increases in the cost of medical care are real and continuing, causing concern by individuals, families, business, government and physicians, and

WHEREAS, much of the increased cost is caused by new technology and treatment methods which result in better care, prolonged life, or a better quality of life, and

WHEREAS, other important factors causing the increases in costs are government regulations, higher labor, energy, malpractice costs, and general inflation, and

WHEREAS, the American Medical Association, American Hospital Association, and Federation of American Hospitals late in 1977 created the Voluntary Effort aimed at moderating increases in hospital charges which have already begun to moderate, and

WHEREAS, the Kentucky Medical Association is participating in a similar Voluntary Effort which has already demonstrated positive results in the Commonwealth, and

WHEREAS, Tom E. Nesbitt, M.D., President of the American Medical Association, called on physicians in his inaugural address to use similar restraint in their fee increases, and

WHEREAS, Hoyt D. Gardner, M.D., President-Elect of the American Medical Association has endorsed this restraint in fee increases, therefore be it

RESOLVED, that the Kentucky Medical Association endorses the call by AMA President Tom E. Nesbitt, M.D. for physicians to help stabilize medical care costs by moderating their rates of fee increases, and be it further

RESOLVED, that the Kentucky Medical Association endorses the Voluntary Effort as a responsible private sector activity to restrain increases in hospital costs without arbitrary limits or government intervention.

Recommendations, Reference Committee No. 4

Reference Committee Number 4 reviewed Resolution A—Voluntary Effort, which was introduced by the KMA Board of Trustees. The Reference Committee recommends that this Resolution be accepted.

(The motion was seconded and carried.)

Resolution L

Campbell-Kenton Medical Society

WHEREAS, it appears there has been no action or reaction by Blue Cross-Blue Shield to Resolution K (Kentucky Medical Association Meeting 1977) to honor assignments of fees by the patients to the physician, regardless of participating or non-participating status, and

WHEREAS, there are still physicians with documented assignments who are not being paid by Blue Cross-Blue Shield or by the patients, now therefore be it

RESOLVED, that the KMA reaffirm its position that the Kentucky Blue Shield should develop a satisfactory method of fee assignment for all Blue Shield services by participating and non-participating physicians; and be it further

RESOLVED, that the Board of Trustees of the KMA be directed to appoint an Ad Hoc Committee on medical insurance problems, and be it further

RESOLVED, that this Committee should make necessary contacts with Blue Shield and other health care insurers and have at least one well-publicized open meeting at which any member of the Association may appear to discuss specific problems relating to health care insurance, and be it further

RESOLVED, that the charge to such a Committee should include but not be limited to:

1) Consider the desirability of maintaining the category "participating physician" with regard to Blue Shield insurance.

2) Consider the desirability of establishing a category "participating physician" with other medical insurers.

3) Consider the method of reimbursing of physicians by assignment of fees as it relates to all medical insurance companies.

4) Consider the relative merits of varying types of medical insurance and draw up an explanation of these advantages to be available to all members of the Association.

5) Consider advantages of making such information available to patients.

6) Consider any other significant matters related to health care insurance determined at the public hearing of this Committee, and be it further

RESOLVED that the results of this Committee's investigation shall be published for all members of the House of Delegates prior to the September, 1979 meeting.

Recommendations, Reference Committee No. 4

Reference Committee Number 4 reviewed Resolution L introduced by the Campbell-Kenton Medical Society concerning Blue Cross and Blue Shield Assignments in reference to UCR policies. The Reference Committee listened to the testimony of many members and guests concerning this Resolution. The Reference Committee recommends that this Resolution be accepted with the following deletion. In the third RESOLVED, the word "open" in the third line should be deleted and the RESOLVED will read as follows:

RESOLVED, that this Committee should make necessary contacts with Blue Shield and other health care insurers and have at least one well-publicized meeting at which any member of the Association may appear to discuss specific problems relating to health care insurance, and be it further . . .

By recommending acceptance of Resolution L, the Reference Committee attempts to answer the objections raised against sections 20.2 to 20.5 of the Report of the Advisory Committee to Blue Cross and Blue Shield in regard to the UCR Program.

The motion was seconded from the floor. Fred C. Rainey, M.D., Hardin County, AMA Delegate, was recognized and made a motion to amend the recommendation of the Reference Committee by deleting the first Resolved of Resolution L in its entirety, and by changing the words "public hearing" in sub-item (6) of the second-to-last Resolved to the words, "general meeting."

A Delegate from Campbell-Kenton County seconded the motion. On a call for the vote, the motion carried.

The original recommendation of the Reference Committee that the word "open" in the third line of the third Resolved (now the second Resolved) be deleted was then considered by the House, and this recommendation was accepted.

Resolution Q

Pulaski County Medical Society

WHEREAS, the primary care physicians of Kentucky have joined together for the first time to form the "Interspecialty Council on Insurance" in June, 1977, in efforts to draw attention of all third-party insurance carriers and the general public to the inequitable differentials in payment levels between primary care procedures and other procedures, and

WHEREAS, primary care physicians have experienced such inequities in differentials in payments to primary care and non-primary care physicians since the first contracts of Blue Cross and Blue Shield were sold in 1948, and

WHEREAS, we agree with the study of the National Academy of Sciences that in order to attract physicians to primary care practice, a number of important changes in the reimbursement system used by third-party payers to remove imbalances in the payment for primary care as compared to non-primary care services is essential, and

WHEREAS, we concur with the above-named study that all physicians within the Commonwealth of Kentucky should be reimbursed at the same level for the same primary care services, thereby discontinuing all geographic differentials in payments, and

WHEREAS, the KMA Advisory Committee to Blue Cross and Blue Shield is inappropriately constituted, consisting of 33% primary care physicians while primary care physicians actually account for approximately 60% of the membership of KMA, and

WHEREAS, the KMA Advisory Committee is a totally powerless committee which apparently acts primarily on requests made by and on agenda prepared by Blue Cross and Blue Shield, now therefore be it

RESOLVED, that the House of Delegates of the KMA either appoint a committee consisting of primary care and non-primary care physicians in proportion to and representative of their numbers within the state, or recognize the Interspecialty Council on Health Insurance as that committee for the purpose of reporting its findings to the House of Delegates and with the privilege of publishing its findings in the KMA *Journal*, and be it further

RESOLVED, that the House of Delegates mandate that appointments to the Blue Cross and Blue Shield Advisory Committee in the future be representative of and in proportion to the number of primary care and non-primary care physicians existing among the KMA membership.

Recommendations, Reference Committee No. 4

Reference Committee Number 4 reviewed Resolution Q introduced by the Pulaski County Medical Society concerning Insurance Procedures and Primary Care Physicians. The Reference Committee listened to many members' testimony concerning this Resolution. Reference Committee Number 4, in support of the Board of Trustees, recommends adoption of the following substitute Resolution:

WHEREAS, Resolution Q has been introduced to this session of the House of Delegates, and

WHEREAS, the Resolution deals with many complex matters related to the methods and levels of reimbursement to primary care physicians, now therefore be it

RESOLVED, that an ad hoc committee be appointed to undertake a complete study of the reimbursement system used by third party payers to remove imbalances in the payment for primary care as compared to non-primary care services and also to undertake a complete study of the composition of the Blue Cross and Blue Shield Advisory Committee as regards representation of primary care physicians on said Committee.

(The motion was seconded and carried.)

Frank R. Pitzer, M.D., KMA Board member from Christian County, was recognized and made a motion that only one ad hoc committee be appointed to consider both Resolution L and Resolution Q, and that the Board of Trustees select the committee members. The motion was seconded from the floor and carried.

Mr. Speaker, I move the adoption of the Report of Reference Committee Number 4 as a whole, as amended.

(The motion was seconded and carried.)

Mr. Speaker, I would like to express my sincere thanks and appreciation to the members of this Committee, Doctor Glenn Bryant, Doctor Don Cloys, Doctor Willis McKee, and Doctor William Yates, and to Mrs. Jean Wayne in the preparation of this Report.

REFERENCE COMMITTEE NO. 4
James A. Baumgarten, M.D., Owensboro, Chairman
Glenn W. Bryant, M.D., Louisville
Don E. Cloys, M.D., Richmond
Willis P. McKee, M.D., Shelbyville
William R. Yates, M.D., Hebron

Minority Report

After listening to lengthy and varied discussions objecting to the UCR Program, as referred to in the Report of the Advisory Committee to Blue Cross and Blue Shield, we feel that no acceptable alternative was offered. We recommend that the Program continue to be administered as it is at the present time.

Respectfully submitted,
Glenn W. Bryant, M.D., Louisville
Willis P. McKee, M.D., Shelbyville

REFERENCE COMMITTEE NO. 5

Ronald D. Hamilton, M.D., Lexington
Chairman

Reference Committee No. 5 considered the following reports and resolutions:

18. Report of the Committee on Maternal and Child Health

27. Report of the Committee on Medicare and Other Governmental Medical Programs

28. Report of the Technical Advisory Committee on Physician Services (Title XIX)

30. Report of the Committee on Community and Rural Health

31. Report of the Committee on School Health, Physical Education and Medical Aspects of Sports

Resolution D—Medicare Reimbursement Areas (Harlan County Medical Society)

Resolution E—Federal Regulations on Minimum Obstetrical Services (Garrard County Medical Society)

Resolution F—Federal Regulations on Hospital Occupancy Rates (Garrard County Medical Society)

Resolution I—Medicare Reimbursement Areas (Letcher County Medical Society)

Resolution J—Medicare Reimbursement Areas (Bell County Medical Society)

Resolution M—MIC Plan for Level I Hospitals (Adair County Medical Society)

Resolution R—Health Systems Agency West Neonatal-Perinatal Plan (Pennyrile Medical Society)

Report of the Maternal and Child Health Committee

The year 1977-78 has been a very active year for this committee. At the beginning of the Associational year the Committee received approval of its previous report by the House of Delegates of the Kentucky Medical Association. This was interpreted to mean that a mandate had been received to continue with the process of defining perinatal care in Kentucky.

The Committee and subcommittees met during the fall and early winter of 1977, and decided that site visits would be performed by teams of physicians composed of committee members at hospitals throughout the State. These visits were to be on a voluntary basis, and a subcommittee was appointed, which devised a questionnaire for the hospitals to be visited. The purpose of these site visits was to hopefully advise the individual hospitals as to their present assets and liabilities in terms of perinatal care, as well as to advise them of the possible steps they could take to improve the quality of care and thereby achieve whatever level of prenatal care they desired.

The bitter winter of January and February of 1978 inhibited the Committee in its actions, and real progress was not made until March of 1978. At this time, pre-site questionnaires were sent to every hospital in Kentucky requesting statistical information about the number of babies born, as well as complications encountered. Also, on this statistical questionnaire were questions about the number of physicians with privileges in the hospital. It was also the intent of this questionnaire to give the ultimate site visit team some basis of background for their evaluation of the hospital and its facilities. As of this writing (July 22, 1978) 27 pre-site questionnaires have been returned to this office, and have been tabulated for the Committee's use.

Twenty-five site visits have been carried out in hospitals in Kentucky by teams composed of a minimum of an Obstetrician and Pediatrician, but usually a perinatal nurse was also in attendance. These visits have detailed the facilities and capability of the hospital in terms of ability to respond to perinatal problems. The questionnaires have been tabulated by the chairman's office, and it is planned to hold a full committee meeting in August or September of 1978 so that discussion of the individual hospital can be obtained.

It is somewhat unfortunate that the East Kentucky Health Systems Agency went ahead and designated hospitals as to Level II capabilities without the full results of the Committee's deliberations being available to them. They were urged to wait for the results of all the Committee's work, but time limitations placed on them did not allow this. Nevertheless, the Committee feels that it has had considerable input into HSA deliberations, and hopefully, will have even more input into the deliberations of the Statewide Task Force, which will make the ultimate decision as to the designation of Level II facilities. The up-coming meetings of this task force lend great urgency to having an early meeting of the full committee so that the evaluation of those hospitals visited can be concluded in the late fall and early winter of 1978. Reports will be sent to the hospitals previously visited so that they may be appraised of their potential assets and liabilities, and may take what remedial steps that they see fit.

The problems the Committee has encountered this year have been largely financial. With no financial support from the Association, secretarial costs, printing, duplication, postage, telephone, etc. costs for the Committee's activities have largely been born by the individual physicians and to a greater extent by the office of the Chairman at the University of Kentucky. Another significant problem was the fact that there was no reimbursement available for the cost of committee members traveling to hospitals, sometimes a great distance from their home offices, and certainly another problem was the fact that there was no financial consideration given to the time spent by nurses. Many hospital administrators were reluctant to give nurses time off from their jobs with full compensation for performing what they considered a non-hospital function. Certainly, it is hoped that if activities in Western Kentucky ever achieve the level of activity in Eastern Kentucky that was encountered this past year, some system be available to pay expenses either by the Western Kentucky HSA or possibly by the KMA.

In all, it has been a pleasure serving as chairman of this Committee, and certainly we feel that the Committee has made progress in this year. Copies of the pre-site visit questionnaire and the site visit evaluation will be available at the Reference Committee meeting, where this report will be considered.

John L. Duhring, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Committee on Maternal and Child Health, commends Doctor Duhring and his Committee on their accomplishments, and agrees with the body of the Report. The Committee recognizes the financial difficulties incurred by members of the Committee on Maternal and Child Health in regard to hospital site visits conducted for the purpose of evaluating perinatal care, and suggests that they investigate possible funding from participating hospitals.

The Reference Committee recommends that this Report be filed.

The motion was seconded and carried with the following amendment proposed by Thomas L. Heavern, Jr., M.D., Delegate from Campbell County:

"The Report of the Committee on Maternal and Child Health be filed and that the KMA Board of Trustees study the financial, legal, and practical considerations involved with site visits or inspections to be conducted by any committee of the KMA."

Report of the Committee on Medicare and Other Governmental Medical Programs

The Committee on Medicare and Other Governmental Medical Programs has had no formal functions this year, as most efforts in this area have been directed to momentary issues, and were undertaken directly by the Board of Trustees.

However, the Committee stands ready to serve in any capacity the House of Delegates might direct.

Frank M. Gaines, Jr., M.D., Chairman

Recommendations, Reference Committee No. 5

The Report of the Committee on Medicare and Other Governmental Medical Programs was considered by Reference Committee No. 5. Considerable debate was heard, and the Reference Committee felt that this Committee should continue to function, but should be given a specific charge and be more fully utilized. The Committee also felt that there should be improved communication between this Committee and the Board of Trustees.

Reference Committee No. 5 recommends that this Report be filed.

A motion was made, seconded, and carried that discussion and action on the Report of the Committee on Medicare and Other Governmental Medical Programs be postponed definitely until Resolutions D, I, and J had been discussed.

Following consideration of the above mentioned Resolutions, the recommendation of the Reference Committee that the report of the Committee on Medicare and Other Governmental Medical Programs be filed was accepted, noting that the preceding action taken on Resolutions D, I, and J called for the Board of Trustees to reappoint the Committee with emphasis on equal representation of all geographical areas and to give it a specific charge.

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The Technical Advisory Committee on Physician Services continues to monitor the activities of the Medical Assistance Program, and to act as a resource for communication between physicians and the KMAP.

Together with the other technical advisory committees, our physician TAC has met each quarter with the Medical Assistance Advisory Council, and has made recommendations and requests based on information initiated by physicians and on issues brought to the Committee by KMAP, for which physician input is needed. Although our Committee's involvement with Medicaid is at times quite frustrating, we are committed to the fact that continuous input on Medicaid through this channel is vital.

Most of the issues that the Committee was concerned with related to physician reimbursement for various procedures. Included in this category were such matters as reimbursement for chromosome studies; reimbursement for a number of laboratory procedures that could be conveniently conducted in a physician's office, for which payment was not made, although the same procedures are reimbursed in-hospital; and reimbursement for formula errors for anesthesiology services.

Other items that the Committee evaluated included lack of physician familiarity with generic substitutions for prescriptions to Medicaid patients; reimbursement procedures for primary care centers treating Medicaid patients; new ophthalmologic procedures; reimbursement for chemotherapy; duplication of patient identification numbers; and Project Integrity, a joint state/federal program that seeks to identify physicians defrauding or abusing Medicaid.

With regard to generic substitutions, the Committee would like to point out that generic drugs cannot be substituted on Medicaid prescriptions if the physician *writes out in longhand* the words "Do Not Substitute." Otherwise, the pharmacist is required by law to dispense the lowest priced generically equivalent he has in stock if it is on the Medicaid Drug Formulary list.

The Committee was asked to review proposed reimbursement procedures for primary care centers, which amounted to a voluminous amount of material. Of most concern was the fact that primary care centers not be reimbursed at a higher level than would a private physician rendering the same services. The procedures adopted would pay primary care centers on a complicated cost plus basis, to the Committee's opposition.

The Committee was consulted by the Program on the medical appropriateness of new ophthalmologic procedures. The specific question concerned their general acceptance in the medical community and eligibility for reimbursement. In this instance, as in others, the Committee does not feel it has the necessary expertise, and recommended referring the situation to KMA's peer review system.

The Medical Assistance Program has encountered the question of reimbursement for chemotherapy treatment where the drug is supplied by the physician. The question relates to the level of reimbursement if the physician acquires the drug and administers it in his private office, as opposed to his acquiring the drug and supplying it to the hospital, where it is administered by hospital personnel. The Committee has not fully considered this yet. After more information is gathered, a recommendation will be made in the next few months.

Some of the membership may have been contacted by the Medicaid Program requesting that their Medicaid records be reviewed. The Committee has been advised that the Medicaid Program is within its legal rights to make this request. Some of these requests were related to the Project Integrity program already described. The TAC received a summary report on Medicaid investigations under Project Integrity and learned that while approximately one-fifth of the 25 cases initiated were referred to the Attorney General for legal action, most of the remainder were settled with the involved physician. Our group was concerned that the federal government had become so deeply involved in what was felt to be a duplicative program, as KMAP already has adequate screening and review mechanisms available to it. This view was expressed to the Advisory Council.

In the early part of the year, the Medical Assistance Program completed a study of physician reimbursement as a result of the physician TAC's repeated reports on the low level of payments in rural areas. According to the report, some 70-80% of charges billed by all physicians are being paid. The Committee is continuing to study the report because of some spot checks made by Committee members around the state on reimbursement levels, which don't agree with the Medicaid report.

It should be pointed out that, beginning with the 1979-80 fiscal year, in-patient services will be reimbursed at the rate of 65% of Medicare allowable rates after the first $50 per line item, and this figure will rise to 70% in 1980, due to increases in appropriations. Also of interest is the fact that a new budget appropriation of $750,000 was made to add new drugs to the Medicaid Formulary list without deleting existing drugs on the list.

I would like to express my sincerest thanks to the Committee members for their dedication and commitment to serving on the Committee. As mentioned before, this work is sometimes frustrating and, at best, requires considerable effort in reviewing background material. I feel they are due some thankful recognition.

Harold L. Bushey, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Technical Advisory Committee on Physicians Services (Title XIX), and commends Doctor Bushey and his Committee for their progress to date. They are asked to continue in their efforts to upgrade physician reimbursement levels to Usual, Customary and Reasonable.

We recommend that this Report be filed.

(The motion was seconded and carried.)

Report of the Community and Rural Health Committee

During the past year the Community and Rural Health Committee met once on May 4, 1978. A majority of the Committee members were present. One of the major health problems in Kentucky, alcoholism, was discussed in detail. A seminar, co-sponsored by KMA with the University of Louisville, on the Medical Management and Special Problems in the treatment of alcoholism was held on May 24th and May 25th, 1978.

The State Alcohol Educational program was updated by Ms. Glenda Snowden, representative from Bureau for Health Services, Educational Division. As a result of legislative action this year, all companies who sell medical insurance in Kentucky must make available upon request, alcohol detoxification coverage on an in-patient basis. There is one catch point, however; if a patient signs himself out of the hospital or leaves the program before the doctor recommends same, all insurance coverage is cancelled with the liability of expenses becoming the responsibility of the patient.

Tuberculosis was our next greatest concern. Since the closing of our state T.B. Hospitals, T.B. seems to be soaring at high levels again. There was a 25% increase in morbidity in Kentucky this past year. Kentucky now has the third highest rate of increase of T.B. in the nation. We feel the House of Delegates at the Annual KMA Meeting should be made aware of this rapid increase.

Our state immunization program is in apparently good shape. Over 81% of our students and children have been properly immunized. This figure is well above the national average. Kentucky's goal is 90%. We are indebted to our Medical Auxiliary for their fine program to aid with the immunizations in Kentucky.

There have been many complaints received about the Premarital Medical Certificate that is presently used. The law states that a physical examination and a blood test for syphilis must be obtained on all individuals getting married. The Committee supports this law and feels that physicians should work with public officials to make sure

that they are aware of the law's full requirements. This will hopefully rectify problems that have occurred over this in the past.

I would like to take this opportunity to thank all my committee members this past year for their help and support.

Don R. Stephens, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Committee on Community and Rural Health, and commends Doctor Stephens and the Committee on their efforts. The Reference Committee particularly noted the information offered concerning the high levels of tuberculosis being reported and the increase in morbidity in the state during the past year, indicating that Kentucky now has the third highest incidence of tuberculosis in the nation. Testimony was heard that indicated emphasis should be placed on diagnosis and treatment efforts in the way of continuing education, and the Reference Committee would like to suggest that the Committee pursue this matter.

Reference Committee No. 5 would also like to commend the Medical Auxiliary for its efforts with the immunization program.

We recommend that this Report be filed.

(The motion was seconded and carried.)

Report of the School Health, Physical Education, and Medical Aspects of Sports Committee

Our committee met three times this year and besides our usual activities several projects were attempted and accomplished this past year.

The seventh Annual Medical Aspects of Sports Symposium this year was co-sponsored with the University of Kentucky, Department of Continuing Education and was held on April 10th and 11th, 1978. We had registration in excess of 250 team physicians, trainers, coaches, and school administrators. It was a very successful meeting with prominent lecturers including the editor of *The Physician and Sports Medicine,* Doctor John Ryan. We were also fortunate to have had Doctor Joseph Torg, noted Orthopedic Surgeon of Temple University; Doctor Robert Murphy, team physician at Ohio State University; Doctor George Gumber, team physician at the University of Kentucky; Mr. Thomas Bell, noted attorney and former NFL League Referee; Mr. Fran Curci, head football coach at the University of Kentucky; Doctor Thomas McLaughlin, Professor of Orthopedic Surgery, Case Western Reserve University; Doctor Harry Bailey, team physician, University of Kentucky basketball team; and Doctor Thomas Schaffer, former team physician and consultant in adolescent medicine at Ohio State. Also, approximately ten to 12 other prominent physicians from around the State participated in this lecture series.

The Committee has reestablished our annual Kentucky High School Athletic Association pre-football season instruction sessions for football coaches and officials. This year the Committee designed a KMA emblem to be affixed to a brightly colored cap, which all team physicians will wear at football games so that they might be easily recognized by the football coaches, football officials and players.

The third item of interest to this committee has been our continuing effort to encourage the Kentucky Department of Education and the Superintendent of Public Instruction, Doctor James B. Graham, as well as the Kentucky High School Athletic Association to certify high school coaches in sports medicine. We solicited letters of support from every active group interested in high school athletes. This included the Association of School Board Administrators, the Association of School Board Members, the Kentucky Association of Physical Education and Health and the Kentucky High School Athletic Association. At the present time we have been advised by the Kentucky Department of Education and the superintendent, Doctor Graham, that as they discuss certification of high school coaches our committee will be invited to participate. No concrete action has been taken by the Department of Education on certification of high school coaches as yet.

This year, with the help of the KMA staff, the Committee did a survey of team physicians in the State. Of 350 high schools in the State, only 135 reported that they had a team physician. Obviously, we feel that more schools probably have a team physician, but we were unable to get a response despite repeated efforts.

Another item that we accomplished this year was the development of a curriculum in sports medicine, which was made available to every college and university in the State to assist them in teaching future coaches and teachers the value of sports medicine.

This year the Committee worked actively with many of the athletic trainers in the State to develop a bill concerning certification of athletic trainers. We are happy to report that House Bill 86 passed the House and Senate and was signed by the Governor and is now law. This law briefly states that all athletic trainers in the State must be certified by a committee of the Board of Medical Licensure. The law also clearly defines the requirements to be classified as an athletic trainer. Also, two members of our committee have been appointed by the Governor to be on a committee of five which certifies athletic trainers. Those two members are myself, Doctor Ronald E. Waldridge, and a former trustee, Doctor Robert McLeod of Somerset, Kentucky.

The Committee is presently involved in preparing for the Kentucky High School Athletic Association preseason football instruction sessions and developing the program and soliciting speakers for the 1979 Medical Aspects of Sports Seminar to be held April 2-3 at the Hyatt Regency in Lexington, Kentucky as a co-sponsor with the University of Kentucky Office of Continuing Medical Education.

The Committee would like to thank the Board of Trustees and officers of the Kentucky Medical Association for their cooperation through the years. We would especially like to thank the staff of the KMA, and most especially Mr. Joe Witherington, whose dedication and competence in his position is unrivaled and for his own office staff, who have been very cooperative and helpful.

Ronald E. Waldridge, M.D., Chairman

Recommendations, Reference Committee No. 5

Reference Committee No. 5 reviewed the Report of the Committee on School Health, Physical Education and Medical Aspects of Sports, and recognizes the importance of progress made in sports medicine.

During consideration of testimony, it was noted that legislation may soon be drafted concerning the availability of a physician at every high school athletic event.

Reference Committee No. 5 recommends that this Report be referred to the Committee on State Legislative Activities with the recommendation that they give further study to any proposed legislation involving sports medicine.

(The motion was seconded and carried.)

Resolution D

Harlan County Medical Society

WHEREAS, the payment system under Medicare Part B for the Commonwealth of Kentucky is discriminatory in that it pays three different scales depending upon geographic location, and

WHEREAS, it is no longer true that the higher per capita income, cost of living or cost of supplies is found only in metropolitan areas, and

WHEREAS, for a number of years the House of Delegates of the Kentucky Medical Association has voiced the desire to see the Commonwealth of Kentucky treated as a single payment scale area, and

WHEREAS, resolutions passed by the Kentucky Medical Association House of Delegates in previous years instructed the Board of Trustees to resolve the Medicare iniquities, now therefore be it

RESOLVED, that this House of Delegates adopt as policy that the entire Commonwealth of Kentucky be considered one single payment area for the purpose of Part B Medicare, and be it further

RESOLVED, that the KMA Board of Trustees request the Part B Medicare carrier to change its reimbursement method to comply with this policy, and if necessary enlist the help of federal agencies and our Congressmen and use all legislative, administrative and legal means to correct this discriminatory payment system.

Resolution I

The Letcher County Medical Society

WHEREAS, the payment system under Medicare Part B for the Commonwealth of Kentucky is discriminatory in that it pays three different scales depending upon geographic location, and

WHEREAS, it is no longer true that the higher per capita income, cost of living or cost of supplies is found only in metropolitan areas, and

WHEREAS, for a number of years the House of Delegates of the Kentucky Medical Association has voiced the desire to see the Commonwealth of Kentucky treated as a single payment scale area, and

WHEREAS, in resolutions passed by the Kentucky Medical Association House of Delegates in previous years instructing the Board of Trustees to resolve the Medicare inequities, now therefore be it

RESOLVED, the 1978 Kentucky Medical Association House of Delegates instruct the Board of Trustees that for the purpose of Part B Medicare reimbursement that for payment purposes the Commonwealth of Kentucky should be considered one payment area.

Resolution J

The Bell County Medical Society

WHEREAS, the payment system under Medicare Part B for the Commonwealth of Kentucky is discriminatory in that it pays three different scales depending upon geographic location, and

WHEREAS, it is no longer true that the higher per capita income, cost of living or cost of supplies is found only in metropolitan areas, and

WHEREAS, for a number of years the House of Delegates of the Kentucky Medical Association has voiced the desire to see the Commonwealth of Kentucky treated as a single payment scale area, and

WHEREAS, in resolutions passed by the Kentucky Medical Association House of Delegates in previous years instructing the Board of Trustees to resolve the Medicare inequities, now therefore be it

RESOLVED, the 1978 Kentucky Medical Association House of Delegates instruct the Board of Trustees of the Kentucky Medical Association to request or demand of the carrier that Part B Medicare reimbursements be made for the entire Commonwealth of Kentucky as a one payment area and if necessary enlist the help of all appropriate federal agencies and our Congressmen and to use all administrative, legislative, and legal means to correct the present discriminatory and inequitable payment system.

Recommendations, Reference Committee No. 5

Resolution D—Medicare Reimbursement Areas (Harlan County Medical Society); Resolution I—Medicare Reimbursement Areas (Letcher County Medical Society) and Resolution J—Medicare Reimbursement Areas (Bell County Medical Society); were considered together by the Committee. The Committee recommends that these Resolutions be rejected and, in lieu of these Resolutions, it was the recommendation of the Committee that KMA reaffirm its policy as stated in the following excerpt from the proceedings of the Special Session of the KMA House of Delegates in February of 1977:

RESOLVED, KMA and this House of Delegates reaffirm our long-standing position that reimbursement be based on current UCR fees upgraded annually on a UCR basis . . .

BE IT FURTHER RESOLVED, this House of Delegates emphatically supports the concept of no designated areas . . .

The Reference Committee also recommends that the Committee on Medicare and Other Governmental Medical Programs be instructed to survey other states to obtain information on reimbursement by their Medicare carriers to discover whether other carriers pay a Usual,

Customary and Reasonable fee or not. The Committee suggests that the Board act on this information and report back at the next meeting of the House of Delegates.

The motion was seconded from the floor and the floor was opened for debate on the Reference Committee's recommendations.

James B. Holloway, Jr., M.D., Chairman of the KMA Board, reviewed the Board's activity in this area during the past years, which included a trip KMA officers made to Washington to meet with members of Kentucky's Congressional Delegation and representatives of the Department of Health, Education, and Welfare.

Following several suggestions, a motion was made, seconded, and carried to accept the Reference Committee's recommendations and that the Board broaden the membership of the Committee on Medicare and Other Governmental Medical Programs to accomplish equal representation from all geographical areas. The motion also directed the Committee to continue to investigate the problem of Medicare reimbursement areas.

Resolution E

Garrard County Medical Society

WHEREAS, recent federal regulations have established standards for the minimum number of obstetrical deliveries needed to qualify for Levels II and III care, and the Eastern Kentucky Health Systems Agency has voted to consider 250 deliveries annually as the minimum necessary for facilities to qualify as Level I hospitals, and

WHEREAS, this House of Delegates in 1977 adopted in principle the concept of three levels of care, but such adoption was not intended to establish minimum numbers which might lead to elimination of obstetrical services in many small community hospitals, and

WHEREAS, minimum numbers of deliveries do not quarantee quality but minimum limits could result in a dramatic reduction in the availability and cost of care, now therefore be it

RESOLVED, that KMA go on record as strongly opposed to placing an arbitrary minimum limit on obstetrical deliveries necessary to qualify for designation as Levels I, II or III facilities and refuse support for this program, and be it further

RESOLVED, that a copy of this resolution be sent to Kentucky's U.S. Congressional Delegation.

Resolution M

Adair County Medical Society

WHEREAS, the East Kentucky Health Systems Agency has the potential for reducing or destroying obstetrical services at small or rural hospitals, and

WHEREAS, the requirement of a minimum number of 250 deliveries per year for Level I hospitals would eventually lead to loss of these services in a number of hospitals, and

WHEREAS, the restriction of community hospital services will have an adverse effect on recruitment of family physicians to rural areas, and

WHEREAS, the National Guidelines "exempt rural hospitals that provide services primarily for uncomplicated maternity cases, and the standard for pediatric service has been limited to urbanized areas," now therefore be it

RESOLVED, that the KMA support high quality obstetrical service throughout Kentucky, and be it further

RESOLVED, that the KMA oppose setting a minimum number of deliveries for any hospital in Kentucky in order to qualify as a Level I facility for infant and maternal care.

Recommendations, Reference Committee No. 5

Reference Committee No. 5 considered Resolutions E and M together. It was felt that the wording of Resolution M was more appropriate, and the Committee therefore recommends that Resolution E be rejected, and Resolution M be adopted.

The motion was seconded from the floor. Thomas L. Heavern, Jr., M.D., Campbell County Delegate, made a motion to amend the Reference Committee's recommendation that Resolution E be rejected, and Resolution M be adopted with the following changes: that the title of the Resolution be changed from "MIC Plan for Level I Hospitals," to "MIC Plan for Level I, II, and III Hospitals," and that the same phrase be changed as it appears in the second Whereas and in the second Resolved; and further, that an additional Resolved be added to the end of the Resolution to read, ". . . and be it further Resolved, that all Kentucky Health Systems Agencies receive a copy of this Resolution."

The motion was seconded and carried.

Resolution F

Garrard County Medical Society

WHEREAS, the Department of Health, Education and Welfare has established a program to mandate the number of hospital beds available to a community by establishing minimum annual occupancy rates through Regulation 42 CFR, Part 121, and

WHEREAS, in many smaller community hospitals, maintaining an occupancy rate of 80%, on an average, is neither possible, nor realistic and may prevent family physicians from practicing in the communities, and

WHEREAS, reduction of beds will not in any way reduce overall costs to the patient or hospital, but may cause a substantial increase in expenses for patients as compared with costs in large city hospitals, and

WHEREAS, this program may greatly discourage needed family physicians from practicing in such community hospitals or discourage them from locating in nonurban areas, now therefore be it

RESOLVED, that KMA oppose this program and take all reasonable steps to abolish or restrict it in Kentucky, and be it further

RESOLVED, that KMA notify all Kentucky's U.S. Congressmen of its concern over and opposition to federally mandated hospital occupancy requirements, and be it further

RESOLVED, that KMA urge its members to communicate with their patients, local civic organizations, and U.S. Congressmen about the potential poor effect on the availability and quality of medical services these regulations may have.

Reference Committee No. 5 considered Resolution F —Federal Regulations on Hospital Occupancy Rates (Garrard County Medical Society), and recommends its adoption with the following amendments. Paragraphs two (2), three (3) and seven (7) should be deleted, and paragraph five (5) should be amended to read as follows: *"RESOLVED, that KMA opposes establishment of arbitrary numbers of beds or arbitrary occupancy rates applied uniformly to all areas."*

The Committee also recommends that copies of this Resolution be sent to all Health Systems Agencies in the state.

(The motion was seconded and carried.)

Resolution F, as adopted by the House in its final form, reads as follows:

WHEREAS, the Department of Health, Education and Welfare has established a program to mandate the number of hospital beds available to a community by establishing minimum annual occupancy rates through Regulation 42 CFR, Part 121, and

WHEREAS, this program may greatly discourage needed family physicians from practicing in such community hospitals or discourage them from locating in nonurban areas, now therefore be it

RESOLVED, that KMA oppose establishment of arbitrary numbers of beds or arbitrary occupancy rates applied uniformly to all areas, and be it further

RESOLVED, that KMA notify all Kentucky's U.S. Congressmen of its concern over and opposition to federally mandated hospital occupancy requirements, and be it further

RESOLVED, that a copy of this Resolution be sent to all Health Systems Agencies in the state.

Resolution R

Pennyrile Medical Society

WHEREAS, WK-HSA approved a Neonatal-Perinatal Plan without due regard to the patient, to the local community, and local hospital, and

WHEREAS, this plan includes potentially 90% of the child bearing women in the Commonwealth, and

WHEREAS, this type designation will adversely affect the ability of the community hospital to recruit new physicians, and

WHEREAS, enforcement of this could economically wreck the small towns and rural communities of the Commonwealth if they are unable to provide physicians to care for industry and business, and

WHEREAS, the KMA had a committee considering the problem for three years and has a position on this issue that was not even considered in the deliberation of this plan, now therefore be it

RESOLVED, that the KMA go on record as resenting this intrusion into our medical affairs and find the plan unacceptable as presented, and be it further

RESOLVED, that the KMA Legal Trust Fund be used to intercede in this matter, and be it further

RESOLVED, that KMA combat this matter to whatever lengths required.

Reference Committee No. 5 considered Resolution R —Health Systems Agency West Neonatal-Perinatal Plan (Pennyrile Medical Society) and recommends adoption of this Resolution with the following amendments. Paragraphs two (2), three (3), and seven (7) should be deleted; paragraph five (5) should be rewritten to read, *"WHEREAS, the KMA had a Committee considering the problem for three years and has a position on this issue that was apparently not considered in the deliberation of this plan, now therefore be it"; and the final paragraph should read, "RESOLVED, that KMA combat this type of arbitrary planning to whatever lengths required."*

The Committee also recommends that copies of this Resolution be forwarded to all Health Systems Agencies in the state.

(The motion was seconded and carried.)

Resolution R as adopted by the House in its final form, reads as follows:

WHEREAS, WK-HSA approved a Neonatal-Perinatal Plan without due regard to the patient, to the local community, and local hospital, and

WHEREAS, enforcement of this could economically wreck the small towns and rural communities of the Commonwealth if they are unable to provide physicians to care for industry and business, and

WHEREAS, the KMA had a committee considering the problem for three years and has a position on this issue that was apparently not considered in the deliberation of this plan, now therefore be it

RESOLVED, that the KMA go on record as resenting this intrusion into our medical affairs and find the plan unacceptable as presented, and be it further

RESOLVED, that KMA combat this type of arbitrary planning to whatever lengths required.

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 5 as a whole, as amended. (The motion was seconded and carried.)

Mr. Speaker, I would like to thank Doctors E. Dean Canan, James C. Embry, John W. McClellan, and Robert E. Smith, as well as Ms. Sharon Heckel, for their assistance in preparing this report.

REFERENCE COMMITTEE NO. 5

Ronald D. Hamilton, M.D., Lexington, Chairman
E. Dean Canan, M.D., Louisville
James C. Embry, M.D., Paducah
John W. McClellan, M.D., Henderson
Robert E. Smith, M.D., Covington

REFERENCE COMMITTEE NO. 6

Cecil D. Martin, M.D., Carrollton
Chairman

Reference Committee No. 6 considered the following reports and resolutions:

10. Report of the Judicial Council
11. Report of the Rural Kentucky Medical Scholarship Fund
22. Report of the Physician-Attorney Liaison Committee

23. Report of the KMA-Kentucky Nurses Association Joint Practice Committee

34. Membership and Placement Services Committee

38. Report of the Committee to Study the Constitution and Bylaws

39. Report of the McDowell House Board of Managers

Resolution B—Membership Dues Incentives for New Physicians (KMA Board of Trustees)

Resolution P—KMA Life Memberships (Gradie R. Rowntree, M.D.)

Resolution S—"Second Opinion" Consultations (Jefferson County Medical Society)

Resolution U—Rules Committee of the House of Delegates (Bennett L. Crowder, M.D., Speaker and Peter C. Campbell, Jr., M.D. Vice-Speaker)

Report of the Judicial Council

The Judicial Council met six times this year and continues to be confronted with a wide variety of situations requiring its attention on behalf of the membership.

A good many of the items brought to the attention of the Council might easily be resolved firsthand by the physician and patient if there were better communication. This applies equally as well to the communication between patients and physicians' employees who sometimes carry out routine office policy without considering the humanistic side of patient relations. Granted that many of the issues brought to the Council are bona fide, there are likewise a fairly large number that are without any great substance. It would behoove all of us as practitioners to give close attention to the personal side of our contact with our patients and to our standard office operating procedures.

The volume of matters the Council has become involved in this year has remained fairly constant. The Headquarters office continues to receive from 10 to 30 phone calls a month and the Council receives at least one formal complaint every two weeks. By way of procedure, the Council most often refers complaints to the local County Society or the Trustee for firsthand investigation and then tries to act on that information together with material furnished by the patient and other appropriate sources.

It is important to point out that the Council's effectiveness is completely dependent on county societies, trustees and other individual members who are called on to help, so we would encourage everyone to assist the Council's efforts when requested.

In the handling of complaints, the Council has established procedures whereby it may refer such matters to those County Societies that have Grievance Committees or Judicial Councils, to the Peer Review mechanism for consultation on fees and other medical practice matters, to the Board of Medical Licensure when situations relate directly to matters of license and on a few occasions to the KMA Committee on Physicians' Health.

It is gratifying to point out that the Council has established a good working rapport with the Licensure Board and our two groups have been able to resolve mutually a number of issues.

With regard to Grievance Committees, the Council strongly encourages all County Societies to establish grievance committees. In many cases, the local Grievance Committee is in the most appropriate position to resolve disputes in the best interest of the patient and physician.

At the beginning of the Associational year, we were pleased to welcome a new member of the Council, Doctor Glenn Bryant, who has served the association in many capacities in past years. Doctor Bryant has been a most welcome and effective addition to the Council and replaces Doctor Sam Weakley who resigned because of the press of other duties.

It would be inappropriate to try to cite all the types of complaints and other items the Judicial Council has been involved in this year, but a brief description of some of them may be helpful to the membership as information.

The Council, in one case, was asked to determine the acceptability of a Doctor of Osteopathy into a group practice. Referring to past precedents, the Council determined that D.O.'s whose practice is based on sound scientific principles or who practice allopathic medicine as determined by local medical peers are acceptable for County Society membership and, therefore, acceptable for group practice.

Several situations were encountered where complaints were made when physicians did not issue itemized Medicare statements to patients until all medical bills had been paid. Referring again to earlier precedents, the Council advised that itemized statements should not be withheld because patients have not paid their bills. This should apply whether a physician accepts Medicare examinations, recognizes a given insurance carrier, etc., or not. Likewise, the Council ruled in one case that whereas the patient has the right to choose a physician, the physician should be able to choose whom he treats so long as care is not withheld in an emergency or in an urgent situation.

With regard to better communications, the Council discovered on several occasions that billing and fee questions were quickly resolved when the attending physician and the patient discussed any problems firsthand.

On two occasions, the Council took action on membership in the Association. In one, a member had been expelled by his County Medical Society and in accordance with the KMA Bylaws, the Judicial Council took a similar action against the member with regard to KMA membership. In the second situation, action was taken against the membership of a physician as a result of his conviction of a felony.

A number of medical practice questions were acted on. In one instance, a complaint was made against a physician because coverage was not provided to patients in the physician's absence. The physician was requested to advise the Council on his coverage policies. The coverage arrangement was found to be adequate and the patient was satisfied with the action taken.

In another situation, physician A had advised a deceased patient's family that some of the patient's medical problems resulted from the alleged use of contaminated supplies by physician B. The family subsequently sued physician B. Autopsy reports indicated that physician B was not at fault and he filed a complaint with the Judicial Council. After thorough investigation, censure proceedings were instituted against physician A who had been injudicious in his advice to the family of the deceased patient.

Another situation brought to the Council's attention was referred to the Licensure Board. The physician in question was frequently associated with liability suits which were apparently not initiated until after his advice on compensation cases was sought. The Licensure Board determined that it would be difficult to prove the physician had violated any law, therefore, they recommended a second opinion be required in cases involving this physician.

A number of other matters were referred to the KMA Peer Review mechanism and one situation was referred to the Committee on Physicians' Health where a physician's illness was a threat to himself and his patients.

In summary, the year has been an active and sometimes arduous one and we much appreciate the work of the Trustees and others who assisted our investigations. Their work was oftentimes long and unpleasant, but vital.

J. Campbell Cantrill, M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 considered the Report of the KMA Judicial Council. The Committee would like to thank the Judicial Council for the timely handling of a large volume of work and echo their request for cooperation from county grievance committees where available. The Committee recommends that this Report be accepted.

(The motion was seconded and carried.)

Report of the Rural Kentucky Medical Scholarship Fund

A new milestone was reached at the 32nd Annual Meeting of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund with the approval of 24 new and 31 renewal loans to medical students for a total loan amount of $220,000. The Fund, in approving these loans, now has a record of having assisted 450 medical students.

The Board also approved an increase in the amount of the loan from $3,500 to $4,000 to all students. The Fund, since its inception, has now loaned approximately $2,000,000 and has 210 physicians practicing in 87 counties. This year, recipients located in the counties of Marshall, Grayson, Greenup, Graves, Perry, Madison and Calloway. Approximately 90 recipients are presently enrolled in medical school or primary care residencies.

Loans are available to residents of Kentucky who have been admitted to an accredited medical school in Kentucky and who will agree to practice in rural Kentucky one year for each loan received. The Board has designated 30 counties as being critical counties according to the physician/population ration and will forgive one loan for each year of practice in a critical county. All notes and agreements are processed at the KMA Headquarters Office. Progress reports are secured on all students in medical school and contact is maintained with residents and past recipients in practice.

The Fund has also provided for Establish Practice loans as an assistance to physicians establishing practice for the first time in one of the 30 designated critical counties and will forgive $1,000 for each year in practice in a critical county. The Establish Practice loan is to be used for the purchase of equipment, supplies and lease of office space.

The Trustees elected Robert D. Hoyt, Ph.D., of Western Kentucky University, and Mrs. Jackie Nicholson, President of the Auxiliary to KMA, as new Board members. The Board of Trustees is especially appreciative of the continued interest and support of Governor Julian M. Carroll and the Kentucky General Assembly.

G. L. Simpson, M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next reviewed the Report of the Rural Kentucky Medical Scholarship Fund. The Committee commends the Scholarship Fund for the "new milestone" that has been reached. We all appreciate their efforts in supplying physicians in underserved areas. The Committee recommends this Report be filed.

(The motion was seconded and carried.)

Report of the Physician-Attorney Liaison Committee

The Physician-Attorney Liaison Committee is composed of three physicians appointed by the Kentucky Medical Association and three attorneys appointed by the Kentucky Bar Association with co-chairmen representing both associations. The Committee serves to establish and maintain a greater degree of understanding between the two professions on matters of mutual concern and serves as a referral body for problems arising between members of the two professions. The basis upon which the Committee functions is the Interprofessional Code adopted by both the KMA House of Delegates and the Kentucky Bar Association.

The Committee did not find it necessary to meet during this Associational year since only two complaints were received, and they were handled by telephone and correspondence.

The Committee once again would like to emphasize that most problems between physicians and attorneys could be avoided by reference to the Interprofessional Code before any formal relations are begun. Copies of the Code can be obtained from the KMA or KBA offices.

Thomas M. Marshall, M.D., Co-Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered the Report of the Physician-Attorney Liaison Committee. The Committee commends Thomas Marshall, M.D. and his committee members for their efforts in providing greater understanding between the legal and medical professions. The Committee recommends that this Report be filed.

(The motion was seconded and carried.)

Report of the KMA-Kentucky Nurses Association Joint Practice Committee

This year the KMA-KNA Joint Practice Committee met several times to discuss important issues confronting our two specialties. As this was a legislative year and since the KNA planned to propose changes in the Nurse Practice Act, the Committee spent much of its time working on developing a new Nurse Practice Act that would be acceptable to both professions.

Physician members of the Committee spent most of one meeting discussing the proposed legislation and recommended certain changes to KNA that they felt would be more agreeable to physicians. Subsequent recommendations of the combined committees were forwarded to our respective Governing Boards and Committees on State Legislative Activities, respectively, for continued research, evaluation and discussion.

The newly-revised Nurse Practice Act will assist the nurses in carrying out many of their duties that they were hard pressed in doing in the past. However, we understand that as with all new legislation, problems will occur, and members of this joint committee stand ready to assist the Association in helping settle these problems, should they occur.

A Joint Practice Seminar was not scheduled this year as it was felt that the legislative session would not leave enough time to adequately prepare for it. The Committee feels that more information on joint practice needs to be disseminated to the physicians of Kentucky. It was felt that the best way to accomplish this education of physicians was to obtain a Health Education Exhibit Booth at the 1979 KMA Annual Meeting. The booth would be staffed by volunteers who are currently working in a joint practice situation. The Committee wants to try this approach in educating the physician first, before scheduling another seminar, possibly in 1980.

In order for a committee to stay abreast of the latest developments in a particular field, it is necessary to periodically attend a workshop or conference. I, therefore, feel that it is important that a physician representative of this Committee attend the Third National Conference on Joint Practice in November in Dallas, Texas. With this knowledge, the Committee can continue its educational program of the medical community and the public on the benefits of Joint Practice. This conference is co-sponsored by the AMA and would be well worth the Association's investment.

On behalf of the physician committee members, I wish to thank my co-chairperson, Sister Francis Scholl, and the nurse members of the Committee, for their assistance in working with KMA. The Committee feels that a good working relationship between the nursing profession and KMA must always be maintained.

My sincere thanks to the physician committee members for their time and devotion.

Kenneth P. Crawford, M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered the Report of the KMA-Kentucky Nurses Association Joint Practice Committee. After lengthy testimony, pro and con, concerning the continuation of this Committee the Reference Committee feels that the KMA needs a continued input for an exchange of ideas to promote a good working relationship between the nursing profession and KMA. The Reference Committee recommends that this Report be filed.

The motion was seconded from the floor, and considerable discussion was heard regarding the committee. On a call for the vote, the Reference Committee's recommendation that the report be filed was carried.

Report of the Membership and Placement Services Committee

The Membership and Placement Services Committee was reactivated in the Fall of 1977 to address the many problems that had developed over membership recruitment and retention, and the distribution of physicians in the State. The Committee met three times during the year to discuss these problems and many others. For your information, I would like to briefly describe our progress and our future goals.

MEMBERSHIP

Membership in the Association has been steadily growing; however, the rate of increase has not kept pace with the increasing number of physicians annually locating in the State. Whereas, years ago, it was an established procedure for a practicing physician to join his county and state organization, it is no longer the case today. Many physicians have located in the State during the past couple of years and have never been invited to attend a county society meeting, let alone be invited to join the Association. I know that many will disagree with my thinking, but I and the Committee feel that it is imperative for the Association to take a more active role in recruiting members, and take the first steps towards establishing a new membership.

To remedy this problem a mail solicitation program was initiated last year, which is used to contact all newly licensed physicians in Kentucky and invite them to join organized medicine. This program has been modified several times and is used by all but five county medical societies. However, no matter how successful this program is, only through personal one-on-one contact will we be able to effectively recruit new members. It is you, the membership, that will have to help and take the first step in welcoming the new physicians to Kentucky and inform them of the benefits of organized medicine.

Along these same lines, the Committee strongly feels that it is important for a county society to select an individual for the position of County Society Secretary, who will actively pursue his assigned task. The reason is that over the next year the Committee will be contacting these individuals often to correlate membership recruitment and retention. Also, with an interested and conscientious secretary many of the communication problems that have resulted between the county and state in the past could help be alleviated.

New steps are now being taken to reestablish membership to the ranks, after they have terminated their membership. Although only 100 individuals drop from the roles each year, many due to relocation out of the State, there are still many who are lost. To help curtail this loss the Committee has initiated a program of personal correspondence and visitation directed at these individuals to determine the reasons for their termination and hopefully to resolve the problem and reestablish these individual's membership. Again, the services of the County Society Secretary will be needed, as will the District Trustees.

The Committee feels that it is imperative for residents, interns and medical students to develop an interest in and become active in organized medicine early in their

careers. Currently, the Committee is surveying the residents of Kentucky on their desire to be organized into their own section within the KMA. The results of this survey will be available later in the Fall of 1978, and upon evaluation of the data collected the Committee will recommend appropriate action. Presently only 13% of the residents in Kentucky are members of the Association. Because of this an intensified mail campaign to recruit residents will be launched during the next Associational year. It is hoped that members of the various teaching hospitals house staffs, who are already members of the Association will be of assistance in helping to recruit more resident members.

Each year many medical students graduate, take their residency in other states and never return to Kentucky to practice. This is regrettable and maybe some of these individuals would have returned to the State if they had become more interested in Kentucky medicine while they were in school. The Committee had an opportunity to meet with several medical students during one of its meetings and discuss the need for more student involvement in the Association. Besides a lack of communication between the Association and the medical schools, it was felt that there was a need to change the student membership structure and dues. The Committee will be undertaking a mail solicitation campaign of students this fall; however, in the future we would like to request that the House of Delegates change the dues requirements for medical students from $10.00 per year to a one time fee of $20.00 for 4 years. This will enable us to establish the student's membership during his freshman year. During the four years, the student would receive all Associational publications and be invited to participate on Association committees and in meetings sponsored by the Association.

The Committee recognizes the University of Louisville and University of Kentucky Chapters of the American Medical Students Association as the medical students organization in Kentucky, and plans to work with these two groups in establishing student membership in the KMA, and help to acclimate these two chapters to the role of KMA. Their relationship to KMA will be stressed and a better rapport obtained.

The contacts and the initial work have begun and through the perseverance of the Committee members we hope to develop a comprehensive membership and retention program that will help strengthen and unify the Association.

PLACEMENT SERVICES

During the past legislative session it was apparent that a strong sentiment in Frankfort was growing to provide physicians to underserved areas in the State, no matter what the consequences were. Organized medicine in Kentucky is viewed as not taking an active enough role in helping to recruit physicians to locate in Kentucky, and it is for this reason that the Committee feels that the KMA should become more active in this area. The Committee feels that the Association should create a more positive image which would show our willingness to help assist communities and the government in decreasing the physician shortage. Currently, the only services KMA offers in this aspect are two placement lists; one is issued quarterly on physicians seeking practice opportunities, and the second is issued bi-annually, listing communities who need physicians. Association funds budgeted for this service are limited and it is the recommendation of this committee that additional funds be provided to expand on this service. As exact figures for this increase are unavailable at this time, we request that representatives from the Membership and Placement Services Committee be able to meet with the Budget Committee when they consider the 1979-80 budget.

The Committee wishes to thank the Board of Editors for agreeing to develop a "Want Ad Column" in the *Journal*, for communities seeking physicians. Space in the *Journal* will be sold to communities at cost and we hope that this service might be of some assistance in attracting some physicians.

The Committee has been researching the possibility of developing a Physician Recruitment Fair, that could be held every two years. The program is envisioned as being held for one day. Those attending as recruiters would be state legislators, county judges and citizen groups from communities interested in obtaining a physician. This group of individuals would attend a morning orientation session, which would give them some insight into what a physician who is ready to locate is seeking in a community. At the afternoon session each community would have the opportunity to display attractions available in their communities and meet with residents and senior medical students about locating in an underserved area. Preliminary discussion with state and local communities indicates a strong desire for such a function to be held and it is anticipated that the State Government will be willing to underwrite most of the expenses. We are still in the preliminary stages of developing this program, but would like the House of Delegates to determine if this is a worthwhile concept to pursue.

The Committee would like to express its thanks to the Staff for its able assistance and especially to Mr. Joseph Witherington for his work for the Committee during the year.

John M. Baird, M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered the Report of the Membership and Placement Services Committee. The Reference Committee appreciates the testimony given by John M. Baird, M.D. The Reference Committee supports the idea of reduced dues as an incentive for obtaining student participation in the Kentucky Medical Association. We recommend that the Committee on Membership and Placement decide the appropriate amount of dues and present their recommendation to the Committee on Constitution and Bylaws for appropriate change. The Reference Committee also supports the activities of the Membership and Placement Committee to develop a Physicians Recruitment Fair and ask the House of Delegates to support this concept. We recommend acceptance of this Report.

(The motion was seconded and carried.)

Report of the Committee to Study the Constitution and Bylaws

Your Committee to Study the Constitution and Bylaws has only one recommendation to make to you this year with regard to updating the Bylaws.

Several years ago, the Bylaws were amended to allow the county medical society to determine the membership category for osteopathic physicians. Under the amended Bylaws, if an osteopathic physician is acceptable to a county medical society as an Active Member, then KMA will accept that physician as an Active Member; if an osteopathic physician is acceptable to a county society as an Associate Member, the osteopathic physician is acceptable to KMA as an Associate Member.

Through an apparent oversight, the section of the Bylaws which specifically states that an osteopathic physician shall be an Associate Member was left in, and as a result conflicts with both the definition of an Active Member and an Associate Member.

Your Committee to Study the Constitution and Bylaws, therefore, feels that a housekeeping change is in order and recommends that Chapter I, Section 2(d), Subparagraph (2) be deleted from the Bylaws so that the section, as amended, will read as follows:

(d) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal government service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

Associate members shall not have the right to vote nor to hold office, but shall receive The Journal *and other publications of the Association.*

Robert L. McClendon, M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered the Report of the Committee to Study the Constitution and Bylaws. The Reference Committee reviewed the Report of the Committee to Study the Constitution and Bylaws and recommends that this Report be adopted.

(The motion was seconded and carried.)

Report of the McDowell House Board of Managers

The McDowell House Board of Managers met on four occasions during the past Associational year at quarterly intervals at the McDowell House in Danville, Kentucky. Attendance at these meetings has been 100% or has approached this figure.

During the year, exterior renovation of the House has been completed at a cost of $15,000. Of this amount, $9,500 was contributed by the Kentucky Heritage Commission. The remaining $6,000 has been taken from the reserves which have been accumulated for this purpose.

The exterior paint has been removed, new paint applied, caulking around the old window panes replaced and, in many areas, deteriorated wooden boards have been replaced. Inspection of the exterior of the House indicates that this portion of the renovation is satisfactory.

In the past year, interior renovation has become indicated at a projected cost of $30,000. A request for funds from the Kentucky Heritage Commission has been deferred at the present time, but the Board has been urged to resubmit its application in the near future, which will be done.

The interior of the House looks very satisfactory at this time except in the back hallway where there is severe peeling of old paint. However, rather extensive repairs are necessary every few years for this 183-year-old house, both exteriorly and interiorly. For this reason, the Board has attempted to save money each year to aid in these necessary repairs. At the present time, $6,000 remain in certificates of deposit, which will aid in the interior renovation needed this year.

During the year the wages of the Secretary, the Assistant Curator and the individuals who lecture to visitors have been raised at least to minimum wage standards. These necessary increases, and the general increase in the cost of utilities, insurance and other necessities make it logical that the Board request some increase in funds appropriated by the Kentucky Medical Association. This is the first request for an increase in many years. This has been approved by the KMA Budget Committee and the Board of Trustees.

During the year, two portraits of close relatives of Doctor Ephraim McDowell have been restored and have made a great improvement in the appearance of these exhibits. The cost of these items has been borne by the Auxiliary of the Kentucky Medical Association, for which the Board is very grateful. The Auxiliary continues to support the House in many ways.

The balance of the lay people and physicians on the Board has been extremely rewarding and valuable for the protection and presentation of the House to the public as a monument to McDowell and a tribute to medical science.

Laman A. Gray, Sr., M.D., Chairman

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next reviewed the Report of the McDowell House Board of Managers. During the discussion of the McDowell House Board of Managers it was brought to our attention by Laman A. Gray, M.D. that only $1,000.00 remains in Certificates of Deposits, not $6,000.00 as reported. We recommend that this Report be filed.

(The motion was seconded and carried.)

Resolution B

KMA Board of Trustees

WHEREAS, increased membership combined with greater physician participation at all levels of organized medicine is essential to the welfare of the profession and the public it serves; and

WHEREAS, new physicians just beginning to establish a practice often find it financially difficult to join organized medicine in the first year of practice, therefore be it

RESOLVED, that a united effort be undertaken by the KMA Committee on Membership and Placement Services and County Medical Society Secretaries to encourage physicians to join and actively participate in all levels of organized medicine, and be it further

RESOLVED, that physicians elected to membership in the Kentucky Medical Association within six months of the completion of their residency, fellowship or fulfillment of government obligated service pay a dues equal to 50% of the regular active KMA dues for their first full year of membership, and be it further

RESOLVED, that Chapter IX, Section 1 of the Bylaws be amended as follows: The annual dues for membership in this Association shall be as follows: (1) Active members, $225 (except those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government obligated service shall pay $112.50 their first year of membership); (2)—rest of paragraph unchanged.

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered Resolution B—Membership Dues Incentives for New Physicians. The Reference Committee heard the testimony on Resolution B and continues to support the concept of membership incentives. The Reference Committee recommends that this Resolution be adopted.

(The motion was seconded and carried.)

Resolution P

Gradie R. Rowntree, M.D.

WHEREAS, the KMA Bylaws currently provide for Emeritus membership status, and

WHEREAS, many sister medical organizations have adopted the term "life" in lieu of "emeritus" as a membership status for those individual physicians who have truly contributed their lifetimes to the medical profession, and

WHEREAS, the term "life" provides the truest connotation of the dedication, commitment and service to organized medicine that many physicians have given, now therefore be it

RESOLVED, that Chapter I, Section 2(b) of the KMA Bylaws be changed to read, "Life Members," in lieu of "Emeritus Members," and that all other necessary changes in this section appropriate to the intent be made.

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered Resolution P—KMA Life Memberships. The Reference Committee heard the testimony on Resolution P and recommends that this Resolution be accepted, and referred to the Committee on Constitution and Bylaws for implementation.

(The motion was seconded and carried.)

Resolution S

Jefferson County Medical Society

WHEREAS, the Medicare administrator in Kentucky has written to every physician in the state to develop a list of physicians who will render second opinions to either Medicare/Medicaid patients, and

WHEREAS, private insurance carriers have contacted physicians requesting that they serve on "second opinion" panels of consultants, and

WHEREAS, the purpose of this request by government and these third party payors seems to be an effort to control or save money, therefore be it

RESOLVED, that the KMA inform its membership and the public with a policy statement on this subject. The KMA statement should be developed by the Board of Trustees, and they should consider the following on this subject:

(a) The use of second opinion consultations in medicine for quality medical care has long been a standard practice and is accomplished every day when patients request or when physicians believe it is in the best interest of quality care;

(b) It is not unethical for any physician to serve on a "second opinion" panel since it has long been common practice and it is a matter of choice for every physician;

(c) KMA should urge that when physicians volunteer to serve as "second opinion" consultants, they strongly request from the government or third party asking for their service, an agreement to provide complete reports or results of any "second opinion" program and its cost and/or any cost savings effectiveness;

(d) It is unethical for the physician who renders the second opinion when requested by an insurance company to accept the patient for a treatment of the specific condition involved;

(e) If the second opinion differs from the first opinion, a third opinion should be requested.

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered Resolution S—"Second Opinion" Consultations introduced by Jefferson County Medical Society. The Reference Committee heard lengthy discussion on this Resolution. The Committee decided to recommend that this Resolution be rejected.

The motion was seconded from the floor. Charles C. Smith, M.D., Delegate from Jefferson County, was recognized by the Chair, and requested that the House consider referring Resolution S to the Board of Trustees for study. A substitute motion to refer Resolution S to the Board of Trustees was then passed by the House.

Resolution U

Bennett L. Crowder, II, M.D., Speaker
Peter C. Campbell, Jr., M.D., Vice-Speaker

WHEREAS, the business of the House of Delegates is increasing with each year, and

WHEREAS, your Speaker has the authority to appoint committees of the House, and

WHEREAS, methodology for handling a number of items as well as formally adopting or modifying rules of order has not been specifically addressed by the House of Delegates, and

WHEREAS, your Speakers are keenly aware of the need for all views to be expressed on any given subject; therefore, in an effort to achieve this we present the following resolution:

RESOLVED, the Speaker will appoint from the House of Delegates five members to serve as a Rules Committee. The Rules Committee will meet prior to each Annual Meeting and submit a report to the House of Delegates for their approval. This report shall be presented at the first session of the House of Delegates during the Annual Meeting and require a two-thirds majority approval of the House for adoption and implementation. For purposes of immediate implementation, this report may not be amended. If amended by the House, it shall be referred as amended to the appropriate reference committee for further discussion and reported back at the second session of the House of Delegates for final action. If approved (by majority), the recommendation will be implemented at the following Annual Meeting.

Recommendations, Reference Committee No. 6

Reference Committee No. 6 next considered Resolution U—Rules Committee of the House of Delegates. The Reference Committee heard the testimony on Resolution U and recommends that this Resolution be accepted.

(The motion was seconded and carried.)

Mr. Speaker, I move the adoption of the Report of Reference Committee No. 6 as a whole, as amended. (The motion was seconded and carried.)

Mr. Speaker, I would like to thank the members of Reference Committee No. 6, Doctors Leslie W. Blakey, James W. Forrester, R. Gary Marquardt, and R. D. Pitman.

We would also like to thank Mrs. Cheryl A. Elrod, our secretary.

REFERENCE COMMITTEE NO. 6

Cecil D. Martin, M.D., Carrollton, Chairman
Leslie W. Blakey, M.D., Lexington
James W. Forrester, M.D., Louisville
R. Gary Marquardt, M.D., Murray
R. D. Pitman, M.D., Williamsburg

UNFINISHED BUSINESS

Doctor Crowder recognized James B. Holloway, Jr., M.D., Chairman of the KMA Board of Trustees. Doctor Holloway moved, on behalf of the Board of Trustees, that the name of J. Campbell Cantrill, M.D., Georgetown, be placed in nomination for re-election to a full four-year term on the KMA Judicial Council. The motion was seconded from the floor and carried.

Election of Officers

Glenn W. Bryant, M.D., Acting Chairman of the KMA Nominating Committee, then proceeded to the podium to give the report of the Nominating Committee. He read the following list of nominations for the positions noted: (*All candidates are selected from the state-at-large.*)

President-Elect	Robert S. Howell, M.D. Louisville

It was moved and seconded that the nominations for the office of President-Elect cease, and that Doctor Howell be elected by acclamation. The motion carried. Doctor Howell was escorted to the podium by several past presidents.

Doctor Bryant continued with his list of nominations:

Vice President	Harold L. Bushey, M.D. Barbourville

It was moved and seconded that Doctor Bushey be elected as Vice President by acclamation. The motion carried.

Secretary-Treasurer	S. Randolph Scheen, M.D. Louisville

It was moved and seconded that Doctor Scheen be re-elected as Secretary-Treasurer by acclamation. The motion carried.

AMA Delegate (1)	Harold D. Haller, Sr., M.D. Louisville
AMA Alternate Delegate (1)	Kenneth P. Crawford, M.D. Louisville

No additional nominations were received from the floor; therefore it was moved and seconded that the nominees listed above for AMA Delegate and Alternate Delegate be elected. Motion carried.

Doctor Bryant then submitted the following nominations for the offices of Trustee and Alternate Trustee on behalf of the district nominating committees:

Fifth District	Walter S. Coe, M.D. Louisville
Alternate	Glenn W. Bryant, M.D. Louisville
Sixth District	Earl P. Oliver, M.D. Scottsville
Alternate	L. Martin Wilson, Jr., M.D. Bowling Green
Eighth District	Richard J. Menke, M.D. Crestview Hills
Alternate	Robert E. Smith, M.D. Covington
Tenth District (one year only)	Richard F. Hench, M.D. Lexington

Alternate (one year only)	Colby N. Cowherd, M.D. Lexington
Eleventh District	Dwight L. Blackburn, M.D. Berea
Alternate	Don E. Cloys, M.D. Richmond
Fifteenth District	Donald C. Barton, M.D. Corbin
Alternate	Emanuel H. Rader, M.D. Pineville

It was moved and seconded that the above slate of nominees be elected. Motion carried.

Election of 1979 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the Nominating Committee for the 1979 Annual Meeting:

W. Bruce Hamilton, M.D., Shepherdsville, Chairman
William E. Becknell, M.D., Manchester
Glenn U. Dorroh, M.D., Lexington
Charles R. Oberst, M.D., Louisville
W. Eugene Sloan, M.D., Paducah

It was announced that the Board of Trustees would hold its reorganizational meeting on Thursday at noon in the Hyatt Suite of the Hyatt Regency Hotel.

Doctor Crowder adjourned the second session of the 1978 House of Delegates at 11:10 p.m.

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1978 CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

Revised September 27, 1978

CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
Article IV.	Composition and Meetings of the Association
Article V.	Officers
Article VI.	House of Delegates
Article VII.	Districts, Sections and District Societies
Article VIII.	Board of Trustees
Article IX.	Funds and Expenses
Article X.	Referendum
Article XI.	The Seal
Article XII.	Amendments
Article XIII.	Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Articles V. Officers

Section 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem

appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline—The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.

Section 2. Membership in the Association shall be divided into nine classes, to-wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine or osteopathy who has served his profession with distinction and who has either reached the age of 70 or has retired from active practice. Emeritus members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8 of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) In-Training Members. Interns, residents, and teaching fellows who are doctors of medicine or osteopathy and who have complied with all pertinent regulations of the Kentucky State Board of Medical Licensure. In-training members shall have the right to vote and receive all publications of the Association, but shall not be counted in determining the number of delegates to which their county society is entitled in the House of Delegates.

(d) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The membership year for student members shall run from October 15 to October 14 of the next year. Student members may not hold office but may be voting members of any committee to which they are appointed. They will be represented in the House of Delegates through one voting representative, a student member of KMA elected by the student body at the University of Kentucky College of Medicine and one voting representative, a student member of the Kentucky Medical Association elected by the student body at the University of Louisville School of Medicine.

(g) Service Members. Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(h) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) Special Members. Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 4. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty per cent of the qualified delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the resolution presents it as an individual member of the Kentucky Medical Association, the resolution shall be signed by him. If the author be a group of members or component society, the resolution shall be signed by the authorized spokesman for that group. Immediately after the resolution has been introduced, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell, and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman) and Distinguished Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee.

Section 19. A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice-President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years, with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years, but no member shall be eligible for election to more than two consecutive full terms as Secretary-Treasurer. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the Committee, and the person receiving the most votes shall be Chairman. In the event that the Chairman so elected is unable or unwilling to serve, or in the event of a tie, the Committee shall elect one of its members as Chairman. The Committee shall meet at such time and place as determined by the Committee Chairman or the Board of Trustees, and shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. The Nominating Committee shall verify the eligibility and willingness to serve of each candidate nominated. The Committee shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. Before noon of the day following the opening meeting, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member may make known his availability for any office within the gift of the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nomi-

nating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, and the Delegates and Alternate Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two trustees to be elected annually by the Board of Trustees. A majority of the full Board, to-wit, 14, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all of the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Secretary-Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement

but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

Section 5. The Journal of the Kentucky Medical Association shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the Journal shall be elected by the Board. All money received by the Journal or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of

Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine should be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Licensure for this purpose.

Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.

Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In the case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation, the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

Section 10. No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications

and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary, ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Members, $225; (except those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay $112.50 their first full year of membership); (2) Life Members, no dues; (3) Associate Members, $25; (4) In-Training Members. $20; (5) Inactive Members, $25; (6) Student Members, $10; (7) Service Members, no dues, (8) Special Members, no dues. The dues during the first year for any active member shall be pro-rated on the basis of the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary-Treasurer of this Association as of the first day of January each year.

Section 2. Unless otherwise provided by the Board of Trustees pursuant to Section 1 hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Sturgis' Standard Code of Parliamentary Procedure, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to evoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 4. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

Section 5. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 7. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 8. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 9. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 10. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 11. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 12. The secretary of each component society shall keep a roster of its members and a list of non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

CHAPTER XIII. AMENDMENTS

Section 1. These bylaws may be amended at any session of the House of Delegates by a majority vote of the delegates present at that session, provided: (1) the amendment proposed is presented in writing to the delegates thirty days prior to the session, or, (2) the amendment is introduced in writing at a regular session of the House of Delegates and considered at the following session, the vote on said amendment having been postponed definitely for a period of at least one day.

Section 2. An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the final session of the House of Delegates, but, not having been postponed definitely for a period of one day, requires a two-thirds vote.

Section 3. An amendment to these bylaws may be proposed in writing by an individual delegate at the final session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the final session is adjourned. Such an amendment having not been postponed definitely for a period of one day, requires a two-thirds vote.

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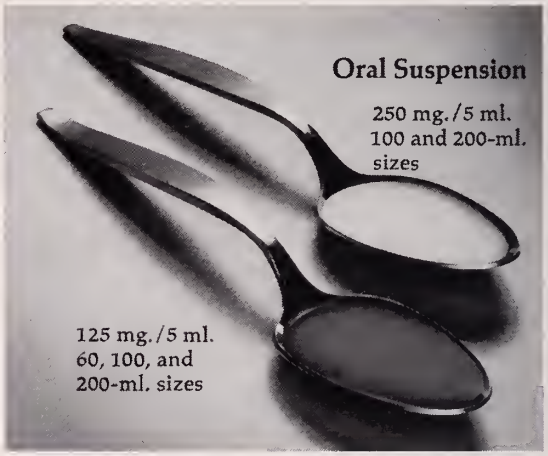

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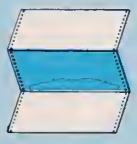

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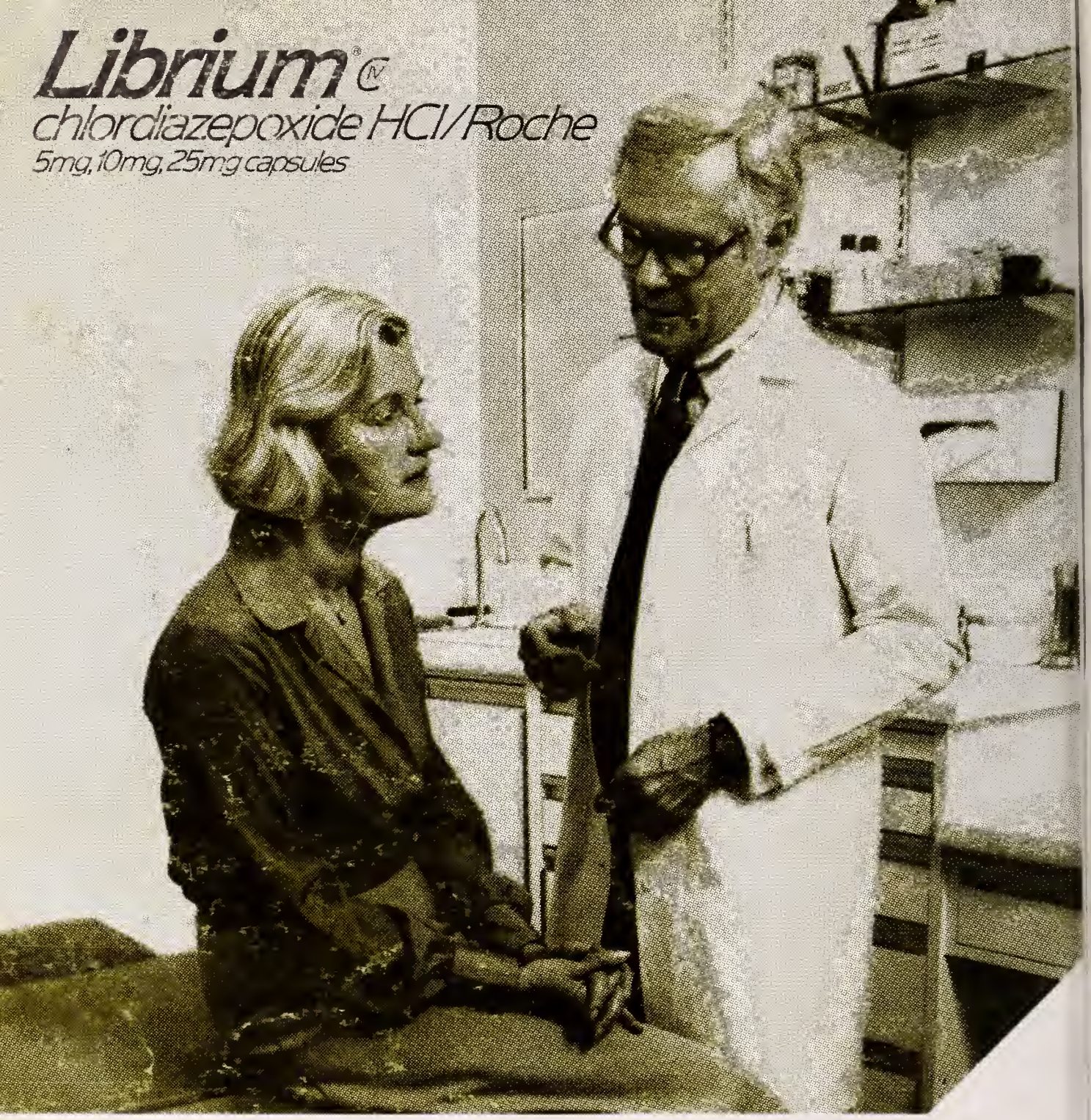

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